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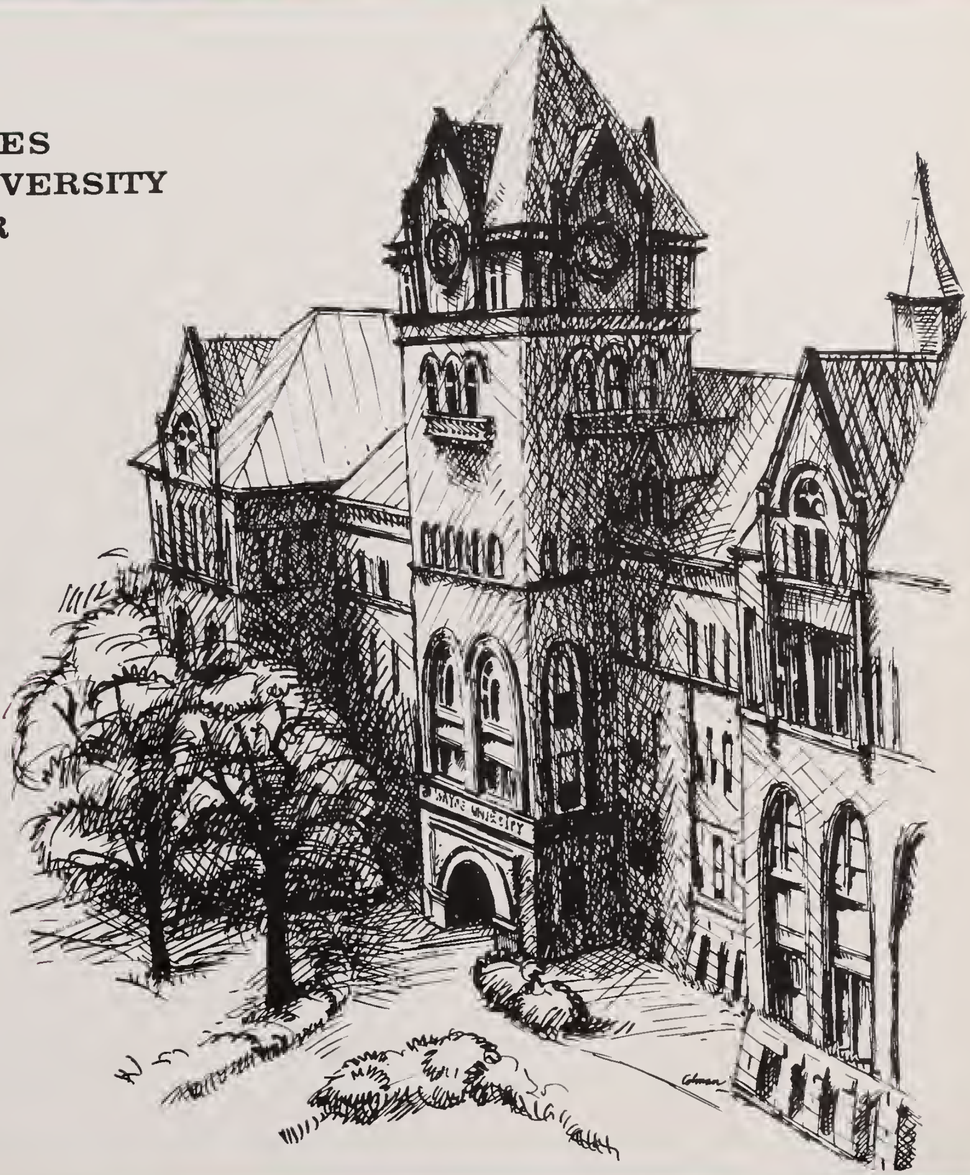
MICHIGAN MEDICINE

THIS ISSUE SALUTES
WAYNE STATE UNIVERSITY
CENTENNIAL YEAR

1/26/68



ICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 1 JANUARY 1968

EXCELLENT ARTICLES ABOUT WSU MEDICAL SCHOOL AND PROFESSORS
PROVOCATIVE VIEWPOINTS
MANY ARTICLES ABOUT UPCOMING MEETINGS
WHERE DOES MSMS STAND RE ETHICS, DISCIPLINE, STANDARDS?
AND MUCH MORE; ALL WITH A NEW 1968 LOOK

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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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MICHIGAN MEDICINE

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ABOUT THE COVER

This issue is dedicated to Wayne State University Centennial, so appropriately the cover features a pen and ink sketch of Old Main. The sketch is by Joanne E. Colman, Detroit commercial artist; and is one of a series of sketches on note paper offered for sale by the WSU faculty wives.

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Prescribing information on next page.

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Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe. skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended. including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Worthy of Comment

This issue of *Michigan Medicine* recognizes the Centennial of Wayne State University School of Medicine. We are proud of their achievements and excited by the projection they envision as they enter their Centennial Year.

The Michigan delegates at the Houston meeting of the AMA House of Delegates were proud to present a resolution extending "congratulations to Wayne State University and its School of Medicine for 100 years of devoted service to the people of the great State of Michigan."

* * *

At the risk of being repetitious I feel the urge to again emphasize the importance of involvement in your society. The 89th Congress has delved so broadly into the field of social welfare that the maze becomes literally incomprehensible even to its sponsors.

Our responsibility for implementation of the programs is awesome. We, the medical profession, must lead the local and state development of the services intended for the provision of more uniformly adequate availability of health services. This requires all of us to give time to a cooperative approach to each project as it develops.

Your state society is staffed to serve as a source for the coordination and research to aid in local programming.

Let me ask how involved you are with your society and its planning?

How actively are your society's committees engaging in your local problems and programs?

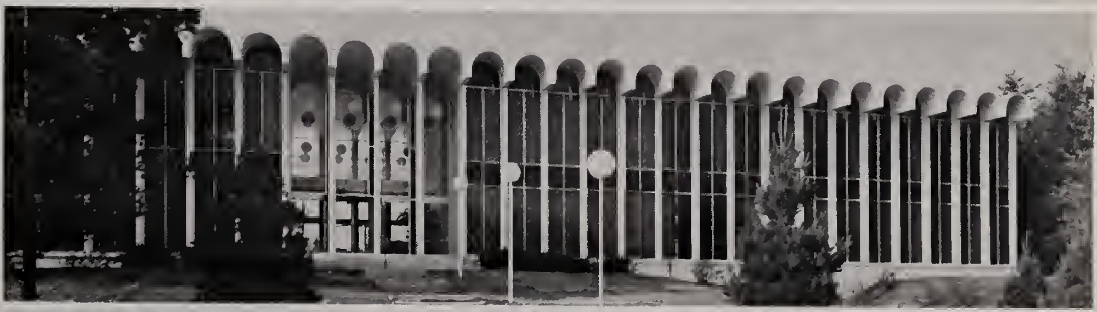
What assistance can our state society executive staff provide you?

* * *

I am sure too that you join me in applauding the "new look" of this January issue of our *Michigan Medicine*. Each year, the cover layout is changed to offer a fresh approach, and each year various changes are made throughout the official journal to improve content and to increase the readability.

Michigan Medicine truly is one of the best state medical journals in the nation as it seeks to provide good postgraduate scientific articles and vital news about MSMS and medicine in Michigan. The state journal has been praised by many for its broad scope of material in the socio-political-economic areas of concern.

Plaudits to The MSMS Council and its Publication Committee, with Brooker L. Masters, M.D., Fremont, Chairman; and also to Scientific Editor George H. Lowrey, M.D., and Managing Editor Herbert A. Auer.



MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

Our Solemn Obligation

BY DONALD N. SWEENY, JR., M.D., CHAIRMAN, MSMS JUDICIAL COMMISSION

Should a Michigan physician lend the use of his name for testimonial advertisements?

Should a MSMS member allow his name — or the prestige of his professional status — to be used in the promotion of commercial enterprises?

These queries are typical of those asked of the Judicial Commission of the MSMS concerning the relationship of physicians to commercial advertising.

We now have some guidance from the Judicial Council of the AMA.

Irate complaints have come from doctors charging that those physicians who do lend their names to testimonials are "prostituting the profession." Some of the complaints stem from a rash of recent newspaper and magazine advertisements and also from book-jacket copy prepared by publishers of books written by physicians.

In rendering its recent opinion, the AMA Judicial Council considered only the advertisements in question. It did not assess the conduct of the physicians involved because (1) no charges had been brought against any physician as an individual and (2) the Council refused to impute improper motives to any of the physicians who, it felt, acted without any intent to violate ethical standards.

The AMA Council concluded, however, that it was imperative to warn physicians of the consequences of providing testimonials without fully considering their potential impact upon the profession.

Here is the opinion rendered by the AMA Judicial Council:

"It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

All of us are subject to forces more powerful than we can measure — the forces of public opinion. A sophisticated public stands by like an enormous conscience noting and commenting on our actions.

It is the solemn obligation of every physician to keep his profession from falling in public esteem. Each of us must help guide others so that not only his responsibility to the profession and to the public be fulfilled but also the standards of medicine be maintained at the highest.

Not the Only Ones . . .

BY ROBERT J. MASON, MD., CHAIRMAN, MSMS COUNCIL

The pilgrimage of many Detroiters this fall to the so-called "bare hand surgeon" in the Philippines, Tony Agpaoa, prompted me to reflect on the relation of faith to medicine and how we should, as a profession, react to situations like this.

This is a difficult one.

We should approach it with a good deal of reverence and caution. I would appreciate very much if you wrote me your reaction to my following comments and any additional thoughts which can help us develop guidelines in how to react to the "Tony Agpaoas."

* * *

We do not know all there is to know about medicine. We do know that the human spirit can be an important factor in recovery from disability and illness.

Many good doctors have received credit from their patients for successful treatment when a substantial factor in the recovery was the patient's faith in both his God and his doctor. It is right that this should be so. We call it "patient confidence" and it grows out of a feeling between the patient and the doctor that recovery is possible.

(In fact, the Medical Society has fought and will continue to fight against any organization, government or person that would disrupt this doctor-patient relationship for it is an integral part of good medicine.)

This does not discount medical science. There are surgical techniques, medicines and machines which can repair bodies, restore function, fight viruses and disease germs, etc. These too are necessary for recovery from most disabilities and illnesses.

It is adequate knowledge of these medical sciences and their relationship to the conditions and diseases of patients that the "Tony Agpaoas" lack. They will always lack these because they have not gone through the necessary schooling and research to find out what scientific aids are available, how they may affect the patient in their various usages, and how and when they should be used. Neither

Continued on Page 8

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

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timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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have they developed the skills and judgments necessary to obtain maximal results from the application of medical and surgical knowledge.

With this lack existing on the part of the "Tony Agpaoas" the results of faith and hope alone cannot approximate the success of faith and hope on the part of the patient plus knowledge on the part of the duly trained and licensed doctor. In fact, without the latter, the patient is giving everything and getting less than he deserves in return.

Some "Tony Agpaoa" types prey on this blazing faith of wonderful people who want to get well. The damage these types cause lies in the delay in proper treatment occasioned by their ministrations and the discouragement that follows their failure.

The medical profession feels a responsibility to protect the sick from "quacks" who cruelly hoax the sick. Quackery *does* exist. Those who claim to do surgery in strange and secret ways are always unethical and usually quacks. That is why we of the Michigan State Medical Society in cooperation with state and federal authorities will hold a series of meetings around the state in 1968 to reveal the methods quacks use.

Insofar as the Agpaoa trip to the Philpipines is concerned, we would recommend against similar trips. Any gain in general health and well being arising from the Philippine sunshine and the spiritual uplift of cooperative effort may be some recompense for the time and money already spent, but we do not believe the travellers received medical treatment. It would seem that that is what most of them need and can obtain right here in Michigan."

The Cults

BY CARL O. RICE, M.D., EDITOR,
MINNESOTA MEDICINE

A system for the cure of disease based on dogma set forth by its promulgator can scarcely qualify as an indispensable health service, nor should any recipient of government benevolence under Medicare be free to choose a system of therapy neither substantiated nor sanctioned by scientific medicine.

If we are to continue to operate a government for the benefit of the people, that government should feel obligated to protect us against health fallacies as well as against other forms of exploitation and chicanery. In the public interest do we not now have such agencies as the Interstate Commerce Commission, the Food and Drug Administration, the Federal Trade Commission, and others operating in their respective fields to protect us from abuses against which we could not individually defend ourselves?

The gamut of health cults runs from ingenuous faith healing to calculated fraud; there have been and may still be extant such "follies" as Autohemic Therapy, Poropathy, and Bio-Dynamo-Chromatic Diagnosis and Therapy, plus 1001 other pseudo-medical practices with no scientific validity. There are pathetically misguided persons who have profound but blind confidence in a copper wire bracelet or a "rheumatism ring" to prevent, alleviate, or cure arthritis; some fanatics ascend 150 steps or more on their knees to reach "miracle" altars or shrines for the cure of their ailments; other gullibles patronize the bonesetter, massager, the mesmerist, or the mere layer-on-of-hands; even the arcane rites of the voodooist or the necromancer can still attract a minority clientele.

Submitting oneself to any type of illegitimate therapy is the prerogative of the individual; but a government should not use tax revenue to support and thereby indirectly endorse such cults. Irrelevant to the issue is that fact that some legislatures may approve licensure of some of the cults.

It is significant that the cults which have been licensed by state legislatures, received the privilege to a limited practice many years ago when the gap between the abilities of the cultists and the medical knowledge of the day was not so wide nor so regrettable as current remarkable developments in scientific medicine have made it today.

It would seem that if many of our honorable United States senators are unwilling to commit themselves unequivocally on this important issue: namely, that of safeguarding their constituents' welfare in the medical field, we may have to become dubious of their sincerity and competence in other areas.

Are we to assume that they have not conscientiously informed themselves on this crucial matter, or that they have yielded to the pressures of wily lobbyists?

And this despite the fact that experts have advised them that medical cults have no sound scientific basis and should therefore be excluded from the health services eligible for government support!

This is no area for congressional compromise!

(Editor's Note: The above soliloquy by Editor Rice was printed with his permission and that of the Minnesota Medicine journal.)

A New Era Dawns For MDPAC

BY V. V. BASS, M.D., CHAIRMAN
MICHIGAN DOCTORS POLITICAL
ACTION COMMITTEE

This could be the dawn of a new era in Michigan politics. There is a new respect for doctors

Continued on Page 15

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.

Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

Here's why Norinyl-1 makes medical sense.

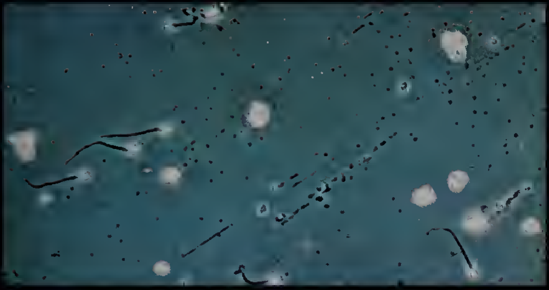
The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

Untreated Patient

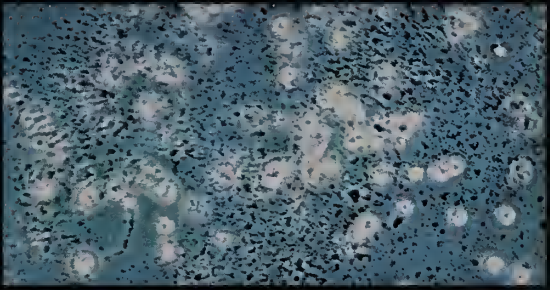
Norinyl-1 Patient

Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

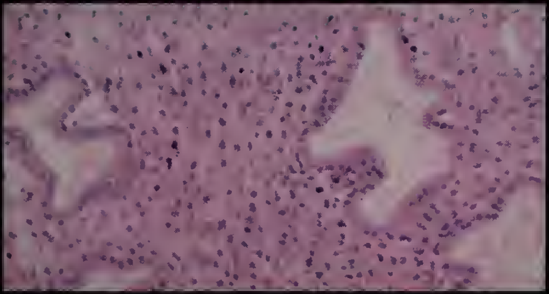
Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



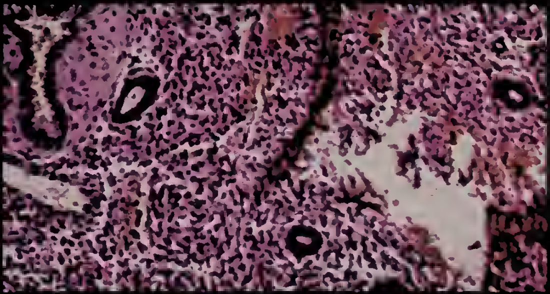
Spermatozoa appear healthy, active, freemoving.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-l.



Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.



Norethindrone in Norinyl-l accelerates secretory phase, suppresses glandular and vascular development.

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(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
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- lower patient cost

An uncommon steroid for common inflammatory dermatoses

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Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

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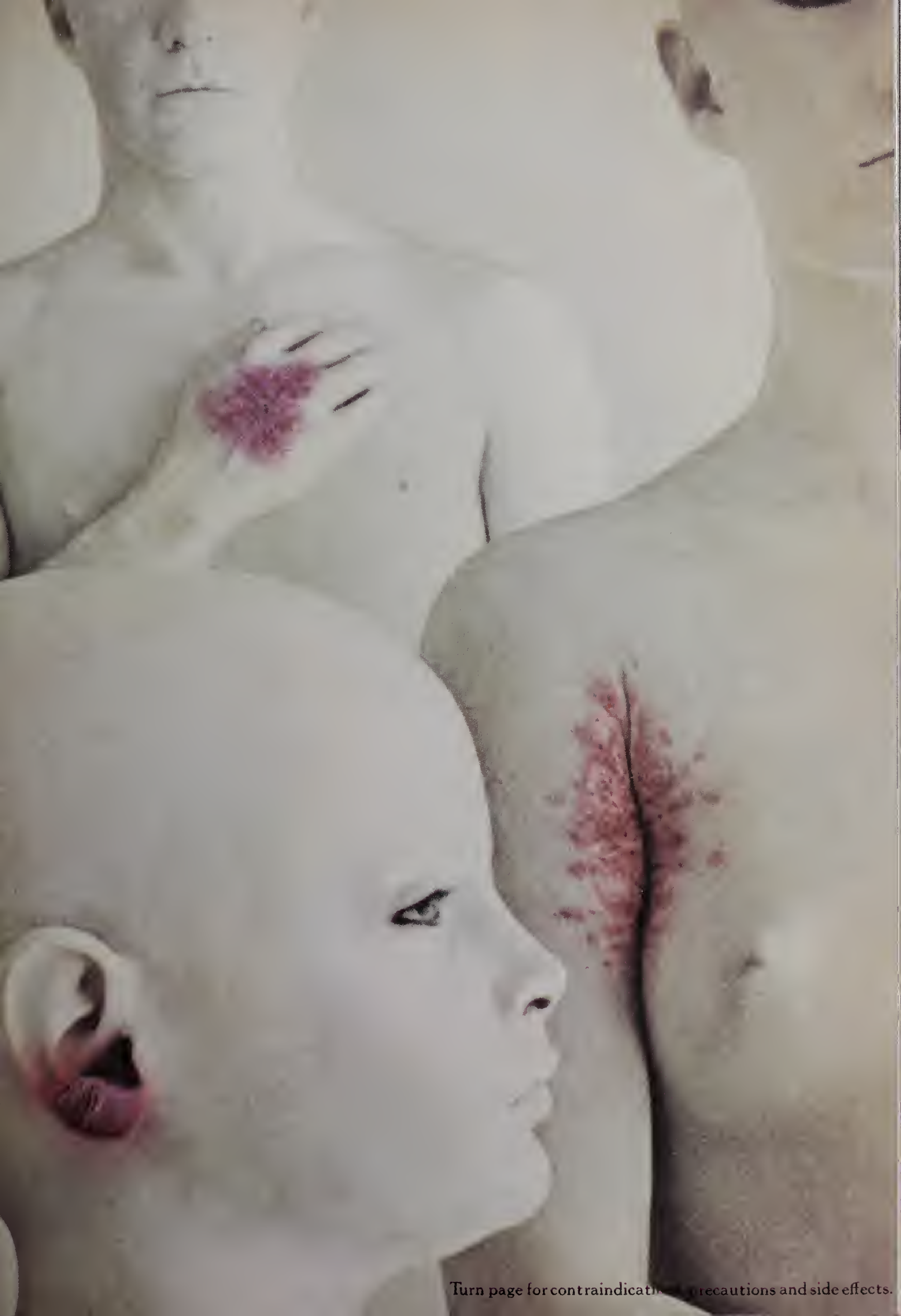

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of medicine who have welded together to form a statewide organization called MDPAC.

Nearly a hundred doctors and their wives hosted a score of legislators, party leaders and members of congress at a recent MDPAC-AMPAC workshop in Lansing.

Legislators from both major parties extolled both our past political effort and encouraged even greater participation of doctors and their wives during the 1968 and future election campaigns.

Doctor Donato F. Sarapo of Adrian chaired the event and merits credit for keeping the program informal and stimulating.

MDPAC was further advanced by action of the 1967 House of Delegates resolution which states: Resolved that, MSMS include the $25.00 donation to MDPAC and AMPAC in its billings, with a footnote that this portion is voluntary and not deductible on Federal income tax returns.

MDPAC can be likened to David of biblical note in his battle with Goliath. Since with a small amount of money, a moral cause (good government) Goliath or the Committee on Political Education of the AFL-CIO and the Chairman of the State Democratic Central Committee, Mr. Zolton Ferency would not have singled out MDPAC in his recent tirade on political funds. Let us remind Mr. Ferency MDPAC doesn't consider party but good candidates for good government.

We are a fund raising organization and supply seed money to campaign committees of responsible candidates.

MDPAC is being noticed by the professionals. We also are becoming more sophisticated in our political activity. Doctors, their wives, and friends from all over the state, are concerned about people, government et al. Our concern is being felt.

Thanks again Mr. Ferency for your recognition.

Join the Team Now

BY BROCK E. BRUSH, MD, CHAIRMAN MSMS COMMITTEE ON PUBLIC RELATIONS

Every day every member of MSMS is responsible for the success or failure of the MSMS public relations efforts.

While every member may not realize it, he is unofficially a member of the MSMS Committee on Public Relations. Every day, every doctor must help solve our complex problems . . . some people are not convinced that health care is available day and night . . . some occasionally may have to wait in a doctor's office . . . some do not believe physicians are interested in the elderly . . . some wish they had closer patient-physician relationships . . . etc.

The projects of the Public Relations Committee are developed and refined from the resolutions adopted by the House of Delegates, from action motions of The Council, from recommendations of the many MSMS committees and from ideas expressed by members.

I would also like to stress the value of AMA Public Relations seminars and meetings. We are able to learn of the programs and techniques used in other states and to exchange ideas on the worthwhileness of a particular effort.

The Public Relations Committee seeks to outline programs in broad general guidelines for the staff to implement by working with MSMS officers, committees, delegates, members, auxiliary members, medical assistants, the news media, schools, etc.

As Chairman I want to recognize the excellent working relationship between the MSMS staff and the PR Committee. The staff continues to suggest workable, unique programs to meet our public relations needs. The staff then takes the broad guidelines approved by the Committee and The Council and carries them out with imagination and dedication.

If we are to combat the accusations that M.D.s are responsible for rising medical costs, for drug costs, and for problems that really are hospital based, we must have total effort of all the M.D.'s as well as the PR Committee and the staff. It is getting to be a bigger and bigger job to keep the record straight.

Ideally every MSMS member should accept the challenge, opportunity and responsibility to serve on the big, every-member Public Relations task force and submit ideas and volunteer for various assignments.

Why Read Journals?

Why do doctors read their state medical society journal?

That question recently was answered by C. Joseph Stetler, President, Pharmaceutical Manufacturers Association, in his address to the Annual Conference of Journal Editors. Mr. Stetler said:

"In the mounting barrage of medical communication hitting the doctor from all sides, the state journal remains notable for its ability to cover the local scene. It provides the doctor with medical articles of special interest in his own area. Usually they are practical articles for the busy physician with new developments being discussed against the background of local conditions. The state journal performs a proper function in reporting on the activities and accomplishments of doctors within the state which no national publication could possibly cover.

"These are important considerations. They give the publications a built-in advantage which makes them uniquely attractive to their readers, and hence enhances their value as a vehicle for conveying an advertising message."

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The Urban University And the Urban Medical School

BY WM. R. KEAST, Ph.D., PRESIDENT,
WAYNE STATE UNIVERSITY
DETROIT

I am pleased to have the opportunity in this issue of *Michigan Medicine* to discuss the responsibilities of Wayne State University in modern society and to focus on the role of our School of Medicine in meeting these responsibilities.

The University began 100 years ago as a small medical college in a post-Civil War city with a need for trained doctors. Today it is a huge urban institution which provides educational services for more than 57,000 people, including 31,000 students seeking degrees and 26,000 in urban extension courses.

It is particularly appropriate that during its Centennial Year the University is developing the theme "The Urban University and Urban Society."

The question to which we are addressing ourselves this year is a special case of an old question concerning the relationship between the University and society. In my opinion, this relationship involves problems that are among the most crucial facing our society and which, if they are not solved, may destroy our society.

UNIVERSITIES MUST PROVIDE the intellectual and moral leadership on which the reconstruction of our cities and hence of American life generally must depend.

The University's engagement with urban problems should satisfy the conditions of university inquiry into any problem whatsoever. These conditions are the obligation to make explicit the principles, value judgments, assumptions, and objectives underlying the inquiry, and the necessity to develop a plurality of approaches and methods of analysis. In so doing, and in encouraging the largest number of various ways of attacking problems, the University will have to find the resources to carry out new social responsibilities on a continuing and not merely on an *ad hoc* basis. It will have to develop an institutional base large enough to take on these responsibilities without prejudice to the other and more traditional obligations and activities of the institution.

IT IS PARTICULARLY appropriate, in considering the theme of our Centennial Year, to consider the vital role of the School of Medicine. Since the end of World War II, all medical schools, especially those in urban settings, have been faced with medical, social, economic, and political developments of extraordinary and unforseen complexity. These include major population increases and changes in patterns of population, changes in patterns of disease, scientific advances at an almost exponential rate, increasing demands for improved delivery of increasingly expensive health care, and rapidly developing governmental involvement in medical education, research, and care. One result is that there are shortages of people in every health professional and technical field.

Many medical schools are expanding and new ones are being planned and started. Nearly all medical schools have been making detailed reviews of the objectives, functions, and curricula.

The School of Medicine of Wayne State University has likewise been engaged in a

AUTHOR

Wm. R. Keast, Ph.D., President
Wayne State University

The present Medical School building at Wayne State University was completed in 1954. At the same time medical classes no longer met at the old building at St. Antoine and Mullet streets. Other WSU photos appear on pages 23, 34, 38, 43, 118.

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major self-study which has resulted in the presentation to the University of a detailed analysis of needs and objectives for the next 10 years.

Since 1945, the School of Medicine has grown more than any other medical school in the United States. The University is committed to an increase in the entering class from 125 to 208 in 1970. In collaboration with private and public institutions it is engaged in the development of a complex medical center which will be of vital importance to the community and the State.

THE FACULTY OF THE School of Medicine has paid particular attention to the following major programs and responsibilities:

1) A program of medical education encompassing the lifetime of a physician, with increasing emphasis on the social, cultural, economic, and political effects upon health and disease and the delivery of health care services.

2) Increasing collaboration with other schools and colleges of the university, because the problems of health involve more than medicine.

3) The development and expansion of strong graduate academic programs as a source of faculty and research strength.

4) Participation in the expansion of educational programs in the allied health sciences.

Urban community health is an inextricable part of the urban difficulties that threaten our society. If they cannot be solved in Michigan, they cannot be solved anywhere. Wayne State University has a vital role in seeking and developing solutions. With its School of Medicine, it is prepared to meet its local, state, and national responsibilities.

Introducing . . .

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Myocardial Infarction - Basic Clinical And Therapeutic Considerations

BY RICHARD J. BING, M.D.
GLEN H. DOUGLASS, M.D.
BOTH OF DETROIT

The current population of the United States as well as that of any other civilized country is menaced by an epidemic of coronary artery disease. Statistical analyses have shown a tremendous increase in frequency of this disease over the last year.[1] This increase is certainly real, and is not due to better recognition by the physician.

Although Herrick described coronary occlusion and myocardial infarction only several decades ago, there is no question that in the last 20 years, the disease has become more common amongst all members of the civilized community. It is evident from the Tecumseh and the Framingham studies that there exists a coronary profile which makes it possible to predict the susceptibility of an individual to the disorder.[2, 3]

IT IS THE PURPOSE of this discussion to discribe briefly some of the basic investigative, clinical and therapeutic work currently undertaken with particular emphasis to this work carried out in this Department of Medicine. This report does not pretend to represent a review of this extensive subject.

Basic Research

The diagnosis of myocardial infarction has profited greatly from basic research. For example, enzyme tests for the diagnosis of myocardial infarction owe their discovery to research in biochemistry.[4] Basic research in coronary artery disease is, in its broadest aspects, both epidemiological and biochemical.

Epidemiological studies have been carried out in many countries and at many centers, and the conclusions reached are that myocardial infarction and coronary artery disease are diseases of civilization and must be related to diet and to the way of living.[5, 6] This epidemiological work is closely related to studies on lipid metabolism and the mechanisms which are responsible for the accumulation of cholesterol and other lipids in the arterial wall.

Despite much research in this field, no definite conclusions have been reached. We still are not certain whether the lipids are synthesized in the vascular wall or whether they reach the vascular wall from the blood."

Isotope studies have suggested that the arterial wall is able to synthesize especially phospholipids.[8] Much basic research in coronary artery disease is related to lipid metabolism, a complex and complicated field which has grown into a separate specialty of Internal Medicine and Biochemistry.[9]

OUR MAIN INTEREST in this department has centered on the biochemical changes that occur in experimentally produced myocardial infarction. This work, carried out by Gudbjarnason has indicated that the early changes occurring after experimentally produced myocardial infarction consist of a rapid activation of a biochemical pathway, the pentose-monophosphate shunt.[10]

The importance of this finding is threefold: First, the pentose-monophosphate shunt furnishes triphosphopyridine nucleotide (TPN) which is essential for the formation of triglycerides, which then are deposited in the infarcted area. Secondly, this pathway furnishes energy for regeneration of the muscle. Thirdly, one is in a position, by studying the activity of enzymes connected with this shunt to follow the biochemical history of the healing of an experimentally produced myocardial infarct. This can be done by measuring the activity of enzymes connected with this biochemical pathway, such as glucose-6-phosphate dehydrogenase.

The studies illustrate that the activity of the hexosemonophosphate shunt can be increased by certain substances such as anabolic steroids, by ascorbic acid, and by insulin and growth hormone.[11] The practical application of these findings awaits further studies.

ANOTHER BIOCHEMICAL approach to the problem of myocardial infarction consists in determining protein synthesis in the infarcted heart. It could be shown that immediately following myocardial infarction, protein synthesis in the area of infarction declines; soon however a marked increase in the activity in the protein synthesis as well as in the formation of nuclecoproteins occurs.[12] This study has been accomplished by following the rate of incorporation of a labeled amino acid (glycine 2-C_{14}) which the tissue incorporates into protein. Of interest are the studies which have shown that these processes commence in the cell nucleus.[12]

Another sideline of this study has been the experimental finding by Braasch and Gudbjarnason that cardiac hypertrophy can result from myocardial ischemia.[13]

This has been demonstrated in animals in which ameroid rings were placed around the three coronary arteries. These rings, first developed by Vineberg, are small steel rings with an inner layer of casein.[14] As the casein absorbs fluid, it swells, slowly occluding the vessel. It has been shown in this laboratory that when occlusion of the coronary vessel occurs rapidly (within a week), hypertrophy of the heart muscle ensues. This is an observation which may have its clinical counterpart in the cardiac hypertrophy not infrequently observed in patients with coronary artery disease.[15, 16]

It is questionable whether this hypertrophy is the result of anoxia or some other factors as yet not understood. The bridge between these experimental observations and their clinical application has yet to be built.

Recognition of Coronary Artery Disease

The recognition of coronary artery disease has been primarily based on clincial findings and on electrocardiographic evidence. An accurate history is still most important in the recognition of arteriosclerotic heart disease. However, as all clinicians know, there are other factors which can produce chest pain and the separation of these factors from myocardial ischemia is not easy, particularly since the electrocardiographic evidence even under stress conditions (exercise) is not always reliable.[17]

For this reason, this laboratory has for the last 12 years worked on other methods which may be helpful in the recognition of coronary artery disease. One of these has been based on the determination of myocardial blood flow, before and after nitroglycerin.[18]

It has been known since the 19th century that nitroglycerin relieves anginal pain. The drug is still a most effective agent. However, the mechanisms of its action were not clear. It has now been shown in this as well as other centers, that nitroglycerin acts on the peripheral vascular bed and relieves angina pectoris primarily by diminishing the demands of the heart for oxygen through diminished inflow of blood to the heart.[19]

However, this may not be the only mechanism of the action of nitroglycerin. Recently, Ogawa and his co-workers in this laboratory have shown that nitroglycerin and related compounds are monoamine oxidase inhibitors.[20] This has been demonstrated both in vivo and in vitro experiments.

It has been known for a number of years that amine oxidase inhibitors may be useful in the treatment of angina pectoris, although the clinical application of these drugs is not practical.

What clinical significance, if any, these data have remains to be seen.

IT WAS MENTIONED in a previous paragraph that the effect of nitroglycerin can now be explained primarily by its peripheral action. Most investigators agree that although nitroglycerin increases the coronary blood flow in normal individuals, it does not do so in patients with arteriosclerotic heart disease. This has been confirmed in

BING

CO-AUTHORS

Doctor Bing is Professor and Chairman, Department of Medicine, Wayne State University School of Medicine, Detroit, Michigan, and Doctor Douglass is Chief Resident in Medicine, Wayne State University School of Medicine and Detroit General Hospital.

Their work is supported by U.S. Public Health Service Grant No. HE-05043 and The John A. Hartford Foundation.

DOUGLASS

this laboratory, using a newly devised method based on the use of a positron emitter, Rubidium 84.[18, 21] This isotope decays by emission of positive charged electrons (positrons). Each positron annihilates with an electron in the body, producing two gammaphotons, directed 180 degrees apart. When these gammaphotons strike a coincidence pair of detectors simultaneously, a count occurs. The method possesses certain advantages. One of these is that the radioactivity of the heart can be readily separated from that of other structures, making complicated collimation unnecessary.[21] A specially designed apparatus is necessary, the design of which is based on the coincidence principle. By recording activity over the right side of the chest, the positron emissions from the heart alone can be determined separately.

In the beginning we used a method in which Rudidium 84 is infused continuously for periods of eight minutes each and the emission from the heart measured over this period. This steady state method has certain disadvantages i.e., rapid changes in coronary flow cannot be assessed, and the method necessitates a computer for calculating the results.

For this reason we are now beginning to use a method in which a single slug or bolus of Rubidium is injected intravenously into the patient; from the myocardial uptake and the activity in arterial blood, the coronary blood flow can then be calculated.[22, 23] This method is technically simpler and does not necessitate computer calculations. Using both these methods it has been shown that nitroglycerin causes an increase in myocardial flow in normal individuals but not in patients with arteriosclerotic heart disease. For this reason the method may conceivably become a valuable adjunct in the presumptive diagnosis of coronary artery disease.[18]

OTHER METHODS FOR recognition of coronary heart disease, used in various clinics, are based on modifications of the Master two-step test. For example, exercise can be graded not by the number of steps a patient takes during the test but by changes in heart rate.[24, 25] Selective coronary arteriography has become the most important advance in the localization of arteriosclerotic changes in the coronaries.[26] The method is invaluable prior to subjecting a patient to surgery for intractable angina pectoris. The fact remains that the method should be used only if the question of operation arises or if the diagnosis of coronary artery disease must be excluded for important reasons.

Some Aspects of Treatment Of Coronary Artery Disease

The value of an operation, devised originally by Vineberg, is designed to alleviate intractable angina pectoris; this procedure has been quantitatively evaluated in this laboratory.[27] The operation consists in the implanation of one or two mammary arteries or arterial grafts into the myocardium. Tschopp and Braasch in this department have evaluated the vascular changes which occur in the hearts of animals subjected to this procedure. They have produced coronary insufficiency by ameroid rings (see above).[27] Following this they have implanted the internal mammary artery into the ischemic myocardium and have measured the vascular capacity as well as the capillary flow in the heart muscle of these animals. The results have indicated that the Vineberg operation produces an increase in coronary capillary flow, preceded by an augmentation in coronary vascular capacity. Whether these results are applicable to man is, of course, not clear but they are certainly encouraging.

A definite advance in the treatment of myocardial infarction during the last years has come from the treatment of Coronary Care Units.[28, 29] The construction and maintenance of such units has become an essential part of hospital planning.

Close supervision of coronary patients is necessary since it has been shown that most of the deaths due to myocardial infarction occur within the first 24 to 48 hours, and that these deaths are due to cardiac arrhythmia, shock and cardiac arrest.[30, 31] Unfortunately, the treatment of cardiogenic shock has been disappointing and cardiogenic shock remains a most serious problem.

It is possible that in the future the construction of artificial heart and myocardial by-pass procedures will furnish a better way for the treatment of cardiogenic shock. Even the excision of necrotic muscle has been attempted with some success. However, shock remains a most serious complication which has so far resisted effective treatment. The treatment of arrhythmias with the

D.C. Defibrillator has resulted in marked diminution in mortality and pacing of the arrested heart has become a relatively simple procedure.[32, 33]

One of the most important features of a Coronary Care Unit is the role of the nursing staff. Physicians are not always immediately available for these emergencies and trained nurses must often perform these emergency tasks.

Prevention of Coronary Artery Disease

This aspect furnishes the best hope for the future.[34] Of particular importance here is a consideration of the coronary profile as was mentioned in a preceeding paragraph.[35] It has been shown that the presence of two of the so-called risk factors predispose a patient to coronary artery disease and possible myocardial infarction. Some of these risk factors are diabetes, hypertension, elevated cholesterol, and genetic factors. The use of compounds (Atromid-S) which lower blood lipids is promising, but as yet clinically unproven.[36]

The relation of mental tension to coronary artery disease has never been reliably established. Hypercholesterolemia certainly is of great importance and so are hypertension and genetic factors. Diabetes plays a predominant role as a risk factor.

How is one to prevent the occurence of myocardial infarction in these coronary prone individuals? A combination of the right amount of exercise with the right amount of diet is important.

An interesting experiment has been carried out in New York. There a Coronary Club has been formed.[37] The members of this club voluntarily subscribe to a diet which is low in saturated fatty acids, and which consists to a large extent of fish and poultry with a marked reduction in the intake of animal fat including beef and hard cheeses. The incidence of coronary artery disease in this group was considerably lower than in the general population.

The Public Health Service has embarked on a very extensive program for the study of myocardial infarction. Wisely, the service is using funds separate from those earmarked for individual research grants. However, we fail to share the pessimisms expressed by some concerning our knowledge of coronary artery disease. It has been said for example, that "A systematic review of our understanding of myocardial infarction and its management produces a startling picture of ignorance".[38]

WE BELIEVE, IN CONTRAST, that a great deal has already been accomplished all over the world and that it is through individual research that most scientific problems will eventually be solved.

Individual initiative and individual efforts will always remain the cornerstone of scientific success and no amount of planned coordination will ever replace them.

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The Detroit College of Medicine is remembered by many graduates. Erected in 1889 at St. Antoine and Mullet streets, it was in use for more than 50 years until it was replaced in 1954 by the present tall building.

The Medical School Deanship: Facts and Fancies*

BY MORTON LEVITT, Ph.D.
DETROIT

Those who have experience in such matters are aware that, in most cases, the defective constitution of German orchestras and the faults of their performances are due to the shortcomings of the conductors (Capellmeister," "Musikdirectoren," etc.) The demands upon the orchestras have increased greatly of late, their task has become more difficult and more complicated; yet the directors of our art-institutions display increasing negligence in their choice of conductors.[1]

—Richard Wagner

In a book which excited considerable controversy in the music world almost 100 years ago, Richard Wagner defined the role of the conductor of an orchestra as simply "to give the *beat* to the band." He made it quite clear that no conductor was qualified to tamper with the composer's work; his job was to keep the orchestra marching in time.

The parallel with the traditional role of the dean in medical education is quite obvious. If we take the World War II period as our water-shed, we find that there were some 77 medical schools in existence in 1941. A number were still proprietary, i.e., they were entirely independent of university affiliation. The total number of medical students enrolled was 22,000, and the graduating class that year was just over 5,000.

ONLY A HANDFUL of schools had anything resembling medical centers; most of the teaching was done in hospitals with whom there was only the most casual legal affiliation; almost all of the teaching was done by private practitioners who served on a voluntary basis; there was only the most superficial interest in and support for research; and today's familiar "three-legged stool" (teaching, research, and service) was largely visible in its patient care aspects. Medical school budgets were small, and administrative relationships with the faculty were casual. The dean did the admitting and excluding of students, often aided by a good secretary; performed the expected ceremonials, and frequently ran a major department of the school or a large private practice as well. In a variety of ways, he admirably filled Wagner's prescription for the conductor of the orchestra.

Without attempting to make any suggestions that things have changed for the better, things have indeed *changed* since the end of World War II.

There are 94 medical schools in operation today, but of the approximately 20 new institutions, only one existing apart from a university has been approved (and even this one has a technical association with an omnibus-type city university), and there is a strong determination on the part of accrediting agencies to see that this number does not increase. There are approximately 33,000 students currently in attendance, and the graduating class next spring is expected to be just under 8,000.

Better than half of the schools today exist in conjunction with an identifiable medical center, and few indeed are the schools that can afford "informal" agreement with affiliated hospitals.

MOREOVER, THE VOLUNTARY teaching base is pretty much a thing of the past. While private practitioners continue to make significant auxiliary contributions to clinical programs, the control of departments has almost entirely passed into the hands of men employed by the school on a full-time basis. A recent study by the AAMC disclosed that American medical schools in 1966 were staffed by some 15,000 full-time faculty members.

Moreover, from the tip of the tail of the dog, research threatens to become the whole dog itself; almost $370,000,000 was spent last year on program support from Federal, State and private sources, and each year sees a substantial increase in over-all support.

Medical school budgets have increased algebraically and consume inordinately large portions of university expenditures. Administrative-faculty relations have become institutionalized with advisory executive committees and faculty senates the general rule; and while appointment of departmental chairmen is still regarded as an executive prerogative, faculty usually serve on selection committees for such positions, and the dean only rarely is asked to meet and/or approve the routine faculty appointments below the chairman level.

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* There are three possible definitions for the term "fancy." Used as a noun (fancier), the *New Century Dictionary* (1959) states "one who imagines, or people who in their speculations . . . are not reasoners but fanciers." On the other hand, *A Dictionary of Slang and Unconventional English* (1961) defines the verb form "fancy" as "to have too high an opinion of oneself, of another, of a thing." Among alternative definitions, this last source offers "a kept woman" and "a warship notable for smartness, but generally very uncomfortable to live in." Here as elsewhere in this land of the free, the reader is invited to "pay his money and make his choice."

TODAY'S DEAN IS not likely to have much to say about admissions or promotions of students, and despite the invariable protestations to the contrary, he also hardly ever retains any real scientific or clinical responsibility. Like his confrere of the past, he still manages the ceremonials of the office. Sad to say, this may be the major context of student contact with him; he greets them formally on Orientation Day, addresses them in a body on a few specified occasions each year, and confers the degree when graduation requirements are completed.

The impersonal nature of his relations with students is hardly a matter of choice, for most deans come to their high position with impeccable credentials in student relations. They have either been chairmen of major departments, or unusually gifted teachers, or as is often the case, served as sub-deans with large responsibility for student affairs. It is therefore hardly lack of interest which keeps the dean from his student charges. It is rather the "big business" nature of his over-all responsibilities which ultimately requires that he delegate more and more tasks to others. Unlike presidents of large corporations, he is relatively poorly paid. Salaries range from $25,000 to $40,000 annually, with the bulk falling into the $30,000 to $35,000 class. This is usually what a young surgical or medical resident anticipates making the second or third year after completion of training.

LIKE LEADERS IN the business, but unlike his academic counterparts in other professional schools, the medical school administrator has shaky tenure. In 1965, "48% of deans had served for less than four years and only 27% had served for more than eight years."[2] The average length of tenure is apt to be something around six years, and since 77% of recent deanship appointments were made from within the school, it can be expected that most of the ex-deans return to academic life at the same institution.

Deans come primarily from the clinical branches of medicine these days, although there is a fair sprinkling of basic scientists, usually from anatomy or chemistry, in the group.

Within the clinical group, internists and surgeons are in the majority, although recently the University of California chose an anesthesiologist, making a kind of "first." There has also been a spate of pediatricians and psychiatrists in recent years who have accepted decanal posts, leading to a rash of probably apocryphal explanations about the faculty being "childlike" or "needing psychotherapy but having tenure."

There is no easy method of identifying a dean's responsibilities by the generic title. Of the 90 some schools currently in existence, 71 have a senior executive officer simply entitled "dean." Fifteen other schools have a man at the controls who also has major university responsibility as well. This relates in the main either to the health sciences (a general category involving medicine, nursing,

LEVITT

AUTHOR

Doctor Levitt is the Associate Dean for Academic Affairs of the Wayne State University School of Medicine.

dentistry, or public health), or to the medical center. This hard pressed group can be readily identified by their titles. They are commonly "Vice-President in charge of ———, and Dean of the School of Medicine."

A few of these managed during their career to give up the deanship while retaining the Vice-Presidency of the university, and they numbered 27 in all in 1966-67.

> *By far the largest new growth is the category of associate and assistant deans. Almost 260 individuals are so identified in the latest roster of the AAMC, and the number is almost equally split between the two ranks.*

Their professional origin is far more variegated than their superiors (one has no formal academic degree, a few have business or government backgrounds, a number are behavioral scientists, but most come once again from the major clinical disciplines), and their responsibilities can be subsumed under a relatively brief list of categories — admissions and student affairs, academic affairs, clinical coordination, postgraduate education, and business affairs.

Irrespective of the number of assistants or superiors, the dean is clearly the "man in the catbird seat." He must represent the university to the medical faculty, the medical faculty to the university, each to the public, and must at the same time operate a business establishment with a total budget which may exceed $35,000,000 annually, and with a capital plant which quite conceivably could be valued at three or four times that amount at replacement cost. He may be responsible for the teaching and research function of up to 4,000 hospital beds in a number of hospitals in a large medical center, be required to set policies for out-patient clinics which treat 400,000 patients annually, and be asked to define the objectives for an educational program which embraces almost 1,000 medical students, 450 graduate students, 500 to 600 interns, residents and fellows, and perhaps 1,500 graduate physicians annually in continuation courses. The above figures admittedly represent the outer reaches. It is unlikely that any one school is accurately pictured in all essentials, but the figures are relatively close for the larger institutions in our land.

> *The drive for the expansion of class size requires ever greater expenditures of time for planning for new facilities, faculty recruitment, and curriculum revision. Medical center direction demands intimate knowledge of real estate operations, of condemnation proceedings, of modern hospital planning, construction, and financing, of the finite details of present day patient care, and finally of the changing patterns of payment for health care.*

The acceptance of research grants by the school usually makes the dean the responsible financial and scientific officer. It is likely that he has been required to sign as consentor to the scientific validity of the original application, and he is certainly held responsible for the financial and ethical conduct (involving humans and animals) of the research. His stewardship is subject to Federal audit, and because of the vast number of developing federal programs involving research, education, and patient care, the dean must not only be *au courant* with grant programs as they develop; he must, in effect, keep well ahead by maintaining sound governmental liaison in order to either support or oppose pending programs.

At the same time, he must be at work formulating plans to implement "passed but not yet funded" legislation. In the words of Dean John E. Deitrick of Cornell University Medical College:

"The schools receive funds from so many agencies and divisions of government and in such amounts that administrative and accounting procedures as presently organized are creaking and are on the verge of breaking down. The National Institutes of Health have found it necessary to hold regional meetings with deans and business officers to explain policies and clarify regulations and acceptable accounting procedures. To many of us, it seemed vital — and I'd like to emphasize this — vital to the future welfare of the medical colleges that we make every effort to develop methods for the intelligent direction of and accounting for these funds if we are to maintain the public confidence in our institutions."[3]

To summarize briefly the above *bouillabaisse*, the life of today's dean is complicated by a variety of factors. Prime among them and in unranked order are:

(1) the immense growth in size of the general operation of medical schools,

(2) the changing nature of community demands upon the medical school,

(3) the expansion of service requirements with

attendant increase in planning, staff, and plants,

(4) the financial complexity of medical school operations,

(5) the development of special programs with consequent highly specialized responsibilities, and

(6) the changing nature of medical education in both its undergraduate as well as its graduate segments.

James Miller has described something called an "information glut" and concluded that "there is a maximum channel capacity for living systems at various levels."[4] One of the most experienced ex-deans, Vernon W. Lippard of Yale, puts the matter more conversationally in the statement quoted below:

> "I have tried to think what the forces are that have interrupted the complacency of the deans and departmental chairmen, or have at least made us conscious of the fact that we are not organized to deal with our administrative problems as effectively as we were 20 years ago . . . I can remember the day when you could formulate a budget some months in advance of the fiscal year and know where you stood. There was never enough money, but you adjusted to your poverty and did your best with the staff and equipment you could afford. Now, sources of funds in the form of research and training grants appear and disappear at odd moments, personnel come and go, and you never know where you stand until some time after the end of the year. Each faculty member is responsible for financing not only his own research but that of a group of postdoctoral fellows and research assistants working with him, and continual vigilance is required by the department chairman to keep the empire builder from building a larger empire than he can properly supervise or accommodate. To this is added new complexities in the financial relationships with our affiliated hospitals. The rule of thumb that universities are responsible for teaching and research and that hospitals are responsible for service used to serve as a basis for determining most of these relationships, but now we have clinical research centers, for example, which must be combined operations."[5]

This article is certainly not meant to be either a plea for "more understanding for the 'poor' dean," or a request for a different set of ground rules for the position. It is rather to be viewed as an effort to set out in all its chaotic ramifications the multiple requirements of the major executive office in the medical school.

The statistics cited earlier do suggest that some deans grow rapidly disenchanted and return to greener pastures. While these may finally be viewed as the wisest of the breed, others (more masochistic, perhaps?) do persevere and attempt to stay abreast of the tide.

THE REAL PROBLEM is that there has literally been a major revolution taking place in medical education over the last 25 years. Other than course titles, and even here there are many innovations, and departmental designations, all else in schools of medicine has apparently changed. This is, of course, in the nature of things, and no serious observer would protest this state of affairs. What is a matter of great concern, however, is the *rate* and *nature* of the change. The changes have come on with such rapidity that they often appear to occur and become accepted as permanent without clear analysis of their long-range impact. Moreover, from extramural sources (professional associations, the government, the public), new challenges, new opportunities, new money and new responsibilities appear daily in bewildering profusion and few schools can resist the lure. Thus we find ourselves engaged in activities for which we are ill-prepared, and lengthy commitments are made in piecemeal rather than reasoned fashion.

Perhaps the time is ripe for the suggestion of a moratorium: no new programs requiring extensive changes in patterns of responsibility should be accepted until the old (post-World War II) efforts have been fully digested, evaluated and understood.

John Corsan has stated "The dean presents the last line of defense in protecting the integrity of the university's educational program . . . Unless deans exert positive direction . . . the program of the institution becomes segmented."[6] The problem is that medical school deans have multiple responsibilities and are often required to act in terms of one set of values and objectives (the educational and research dimension) and sometimes in terms of another (the hospital, patient care, and community dimension). It is quite simple (and also naive) to say that a nice balance should be sought between the two dimensions, that the medical school administrator should attempt to exert himself in both areas of responsibility without sacrificing either.

TIME HAS DEMONSTRATED that this is impossible, and that there is something manifestly wrong in an organization which requires a complete change of management each five or six years, on the average. One dean of a West coast medical school was interviewed by the local newspaper when he decided to give up the reins and return to the laboratory. He frankly admitted to the reporter that he had been disappointed by his failure to successfully work out necessary affiliation arrangements with certain hospitals. When the reporter persisted and asked what traits his successor (still being sought) should have in order to solve the problem, the dean looked pensively out the window for a long moment and then answered "like Jesus Christ."

And here we come face to face with the parallel to Wagner's quotation ("The demands upon the orchestra have increased of late, their task has become more difficult and more complicated"). Like Wagner who blames the trouble upon "the shortcomings of the conductor," the faculty, the university, hospital administrators, and medical societies are apt to charge off the shortcomings of the system to the inadequacy of the dean who in reality may be almost powerless in the face of "demands" and "complications."

It must be stated finally that the best medical schools are not necessarily the most highly organized nor is the vague shibboleth known as "better business organization" likely to yield any real change. We already have a regimental superstructure of vice-presidents, deans, sub-deans, directors and department chairmen, each of whom does three of four different jobs with varying degrees of interest, spontaneity, and competence. It is likely that each has been drawn to an administrative position because of the challenge involved. This challenge usually is related to the idea that each man can alter the system in some definable way, that as a consequence of the singularity of his efforts, his imprimatur will be visible for all to see.

The truth is that medical schools today are being asked to or are asking for far too much responsibility for health care, often to the detriment of their original charge as educational institutions. No other school in the university is routinely expected to play so active a role in the community, and none is so likely to become strangulated by new demands as the medical school.

The combination of internal and external forces focusing on the institution creates top-heavy administrative responsibility, and the wary dean turns to assistants for help. Because they are likely to be scientists, much like himself, they, too, fast become innundated by the perplexing details of business, accounting, budgeting and real estate practice, and a move is usually made at this time to bring in business specialists. This effort, well-reasoned on the face of it, brings some temporary help, but it, too, founders sooner or later for there is something about education in general and science in particular which is unrelated to sound business practice.

Scientific discoveries cannot be programmed, education is certainly "uneconomical" (schools spend money, not make it), its projects, costs, and values cannot be charted in any linear fashion, and the effort to bring order out of disorder by business-office techniques often results in still another complication. Even when this last stratagem is successful, it is apt to succeed in a way which makes the dean "penny-wise but pound foolish." He may well run a taut ship, but educational innovation suffers because faculty spontaniety and ingenuity are stifled.

IT IS THIS last point which brings me to the heart of the matter.

The major reason, perhaps the only reason, for the existence of administrative officers in educational institutions, is to create an atmosphere which is genuinely conducive to student learning, to faculty growth, and to scientific discovery. If the medical school dean has any competence, it is certainly in relation to the educational process, not to sound business and management practice. Attracted to his new position by the educational challenge, he becomes entrapped by organizational complexities to the detriment of all.

Few question the premise that educational institutions must preserve their own traditions while at the same time responding to the changing society which they serve.

Almost two decades of service in a medical school convince me that we guard our tradi-

tions too lightly in medical education, and perhaps have become overly responsive to new programs, innovations, and demands upon us for service.

Each new program brings new promises, new complexities, new requirements, and new responsibilities. Some offer the hope for realistic solutions to an immediate problem in a way which is consistent with the purposes of an educational institution; others are related only peripherally to our major goals.

Let us do the former when we can; let us avoid the latter whenever possible; but most of all, let us think seriously about the major objectives of a medical school and then direct our energies to the accomplishment of these tasks.

Only when we have met our first responsibility to provide the soundest and most stimulating educational environment for our students and faculty (and few of us can currently boast of such an accomplishment) are we justified in trying to undertake the overwhelming task of providing high-quality health care for the community at large. There is no question that the medical school's most effective contribution in these days of changing public expectation still lies in its ability to provide *models* of excellence which can be replicated elsewhere by those community institutions which have the time, resources, and that general responsibility.

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A Short History Of Wayne State University School of Medicine

By Leslie L. Hanawalt

The regular teaching of medicine in Detroit began in 1868, when five young physicians incorporated the Detroit Medical College. These men established their college on Woodward avenue in two surplus buildings of the Civil-War Harper Hospital, leased to them free by the Harper trustees in return for free services they rendered to Harper patients.

Though no one in Detroit dreamed of a university at that time, these five educational adventurers became unwittingly the earliest founders in the history of the colleges that constitute what is now Wayne State University.

These founders had good social and financial connections. Theodore A. McGraw's father was a Detroit merchant, as was the brother of David O. Farrand. Samuel P. Duffield's father was a prominent Presbyterian minister and George P. Andrews' a medical missionary. Edward W. Jenke, 35, the oldest of the group, was the son of an Indiana land-developer and educator and the son-in-law of railroad magnate James F. Joy. All five were on the staff not only of Harper Hospital but also of the older and larger St. Mary's Hospital operated by the Sisters of Charity near downtown Detroit.

FOR INITIAL CAPITAL they depended on subscriptions made by themselves, their relatives, and 32 other well wishers. With it they built a central structure connecting the two Harper buildings, and furnished an amphitheater lecture room, a dispensary, and space for the laboratory courses, chemistry and anatomy. After the college started, they paid operating expenses from student fees only, public support of professional schools being almost unknown in America. Like nearly all medical schools, this one paid no salaries. The faculty earned their livings by private practice.

Training for the M.D. degree consisted of courses in the seven standard fields: physiology, chemistry, anatomy, materia medica (elements of what we call pharmacy, pharmacognosy, and pharmacology), surgery, obstetrics, and practice of medicine (including dispensary work). Ophthalmology was an extra. Students had to attend two "years," that is, two four-month "regular terms." These could be augmented by a free brief "preliminary term," and, a little later, by a summer term. A student's fees for the two-year course totalled about $150. Since most of the students were not Detroiters, they had the further expense of board and room at $3 to $5 per week.

The initial faculty was twelve physicians, only three of them over forty years old. They had earned their M.D.'s at some of the best medical schools, chiefly in New York City, and all held places on the hospital staffs. Five had been seasoned in Civil War army hospitals, three had studied in Germany, several are still included in modern biographical reference books. They were motivated by desire for the prestige that went with the title "professor," for the privilege of training new doctors, and for the chance to learn by teaching. They were in earnest about improving themselves and the profession. Several had recently taken part in reviving the defunct Michigan State Medical Society, in forming the Wayne County Society, and in founding the *Detroit Review of Medicine and Pharmacy*. Those who became best known in following decades were Drs. McGraw (surgery), Andrews (principles of medicine), Jenks (gynecology), and Henry O. Walker (anatomy; later surgery).

THE FIRST STUDENT body was 48 men, 33 of whom transferred from other medical schools after a year's work and constituted the first graduating class, that of 1869. A majority of these 33 came from the University of Michigan's medical school, attracted by the superior clinical facilities that the Detroit college enjoyed in the city's hospitals. Until about the time of the Civil War, the common mode of American medical-school teaching had been "didactic," with bedside experience left to the hometown preceptorship; but now there was a strong movement toward systematic clinical instruction that went much beyond what was available under a preceptor. This is one reason why medical colleges multiplied in the cities. In the next 20 years, enrollments at the Detroit Medical College varied from 50 to 133 and graduating classes from 14 to 43.

A rival, the Michigan College of Medicine, was founded in 1879 on the lower east side of Detroit by a group of doctors in much the same way as the earlier college had been formed. Intense rivalry ensued between the two schools until 1885, when they merged, becoming the well-known Detroit College of Medicine. This institution thrived and in 1889 constructed on St. Antoine street, across Mullett from St. Mary's, a large new building which stood until 1960 and is remembered by many readers of *Michigan Medicine*.

About this time, in the midst of national prosperity and optimism, the college trustees conceived the amazing idea of forming a university, including a division of liberal arts. The first steps (1891) were a Department of Veterinary Surgery, another of Pharmacy, and a third in Dental Surgery. The financial panic of 1893 demolished the university plan, but the three new departments endured respectively till 1899, 1905, graduating a total of 590 men and women in pharmacy and dentistry. They of course augmented the enrollment of the college; and since the Medical Department also grew fast, in the late nineties the student body often ran more than 400 and a year's graduates more than 100. The ancillary departments were closed by the trustees for financial reasons; they could not pay their way on student fees, and thus became a burden on the Medical Department.

THE HEYDAY OF THE Detroit College of Medicine was the 1890's. By that time medical science was being revolutionized. European research of preceding decades, publicly subsidized, was beginning to pay off. The work of Virchow, of Pasteur and Koch in the bacterial causation of many common diseases, and of Lister in antiseptic surgery routed the old simplistic disease-theories of Benjamin Rush and others, and became the foundation of the sciences of bacteriology and pathology. The new concepts became systematized in textbooks. Vaccines, antitoxins, public-health measures, and other weapons against disease caught the imagination of the public, which felt a new confidence in its physicians.

The M. D. course of study at the Detroit College was lengthened to four years in 1895; new laboratories crowded the main building and a second that was completed in 1897; German-trained teachers grew in numbers; internships, though not required by colleges or licensing boards, began to appear; and the marvelous possibilities of the x-ray—the third great medical boon of the 19th century after anesthesia and the germ theory—began to be dimly perceived. Curricular standards constantly rose.

The necessity of expanding science instruction meant, however, that financially the old colleges could no longer subsist on fees. Laboratory teachers had to spend so much time at the colleges that their private practices suffered, and the colleges increasingly had to pay them salaries. Dozens of colleges closed, and others joined universities in order to get support. The Detroit College of Medicine attempted sporadically until 1917, generally with the encouragement of the state medical society and some of the Ann Arbor faculty, to make an alliance with the University of Michigan's medical school; but the University's regents resisted the separation of any instruction from the campus in Ann Arbor.

IN 1913 THE college reorganized and reincorporated as a non-proprietary institution and raised a considerable fund, chiefly among alumni, to improve the laboratories and pay several full-time salaries in the basic sciences; but this money did not last long. Early in 1918, to preserve the college for the wartime production of doctors and for incorporation into a future municipal university, Detroit's Board of Education, by an arrangement unique in the United States, took over the debt, property, support, and control of the college.

In these early decades of the century, many teachers came into the faculty who were destined to long terms of service. Among them were Dr. Charles D. Aaron, Raymond C. Andries, Max Ballin, John N. Bell, Andrew P. Biddle, William

AUTHOR

Professor Hanawalt has been a member of the Wayne faculty for 38 years and is now the WSU historian. He is the author of the recent **A Place of Light,** the history of the University published by the WSU Press.

E. Blodgett, Frederick G. Buesser, Don M. Campbell. J. Henry Carstens, Fred H. Cole, James E. Davis. William M. Donald, Hugo A. Freund, Charles G. Jennings, Louis J. Hirschman, B. Raymond Hoobler, Augustus W. Ives, Charles S. Kennedy, Guy L. Kiefer, Dean Walter H. MacCraken, William C. Martin, Angus McLean, Richard E. Mercer. Stanley G. Miner, Grover C. Penberthy, J. Milton Robb, William J. Seymour, Dean Burt R. Shurly, William J. Stapleton, Jr., Frank B. Walker, H. Wellington Yates.

The years between World War I and 1935 were a time of difficult struggle, under Dean Walter MacCraken. Annual budgets rose from $50,000 to $240,000 and enrollments from 136 to 401; clinical teaching in the hospitals, notably in the new Receiving Hospital, became better systematized and controlled; admission and graduation requirements were raised in accord with national standards; a new six-story building relieved the pressure on the two old ones; some original research was attempted.

THE DEPRESSION YEARS brought new crises and new challenges to the medical school in its efforts to match rising standards and costs in medical education. From 1936 and the deanship of Raymond B. Allen dates the School of Medicine's rise in stature and national status.

To describe this rise would require a separate article. Key men in it have been Deans Allen, Gordon H. Scott (now a University Vice-President), and Ernest D. Gardner — and one is tempted to begin listing also a score of other veterans such as Gordon B. Myers, Osborn A. Brines, Charles G. Johnston (all deceased), Arthur H. Smith (retired), Muir Clapper, Fred L. Rights and Walter H. Seegers.

One revealing index of growth and change is the annual budget, which in 1966-1967 mounted to $10.9 million. Registration figures provide another barometer. This fall there are 536 men and women enrolled in the undergraduate medical program. Another 200 students are enrolled in medicine-related bachelor's programs and graduate programs leading to the Ph.D. and master's degrees.

CURRENTLY THERE ARE 300 fulltime faculty members and research associates. In addition, the School secures the invaluable parttime services of 80 faculty members and research associates, and nearly 900 voluntary faculty members.

Alumni of the School of Medicine now number 3,042, including the 100 graduates who received their Doctor of Medicine degrees last June. Sixty-seven per cent of Wayne's medical alumni are in practice in the State of Michigan.

The School maintains affiliations for teaching and research with Detroit General Hospital (Receiving and Herman Kiefer Branches), The Grace Hospital, Children's Hospital of Michigan, Child Research Center of Michigan, Harper Hospital, Lafayette Clinic, The Rehabilitation Institute, Detroit Institute of Cancer Research, Hutzel Hospital (formerly Woman's Hospital), Sinai Hospital, Veterans Administration Hospital in Dearborn, Wayne County General Hospital in Eloise, Hurley Hospital in Flint, St. Luke's Hospital in Saginaw, and Borgess Hospital in Kalamazoo.

As compared with 1936, the physical plant of the School has changed beyond recognition. The two 19th-century structures were abandoned in 1954 and replaced by a building for the Department of Occupational and Environmental Health, which stands alongside the 1927 library-laboratory building on Mullett Street. Eastward on the Chrysler Freeway is the large Medical Science Building in 1954 transformed the School's general teaching environment.

FAR TO THE NORTH of the present medical campus is the emerging Detroit Medical Center where Wayne is building its new medical complex. First structure to go up was the $4 million Medical Research Building, completed in 1964. The new Basic Science Building, scheduled for completion in 1970, will house six of the School's 24 departments and will allow an increase in the entering class of medical students from 130 to 200.

Plans for the School also call for a $2 million medical library, an outpatient clinic capable of serving 250,000 patients a year, a conference center, a gerontology center, a vivarium, and parking structures. Total cost of the new medical campus, covering some 25 acres is estimated at $56 million for land, present and proposed buildings.

Few medical centers in the United States will match Detroit's. Thus within a half-dozen years, the Wayne State University School of Medicine will be the unifying feature of such an investigative and therapeutic complex as the five founders, a century ago, could not in their wildest dreams ever have imagined.

Pneumoconiosis - Diagnostic Considerations

ARTHUR J. VORWALD, M.D., Ph.D.
DETROIT

In a broad sense, the term "pneumoconiosis" connotes only a pulmonary condition provoked by the inhalation of particulates, but without implications concerning subjective and objective medical findings. There is some divergence of opinion regarding that connotation. Accordingly, the term is used often in a more restricted sense which implies that the inhaled particles are toxic, and thereby have causal and/or aggravative relationships to the pathology in the respiratory tract and lung and to the attending clinical manifestations.

In any event, the diagnosis of a pneumoconiosis necessitates consideration of a number of variable factors. These may operate independently or in combination, concurrently or sequentially, to determine whether or not the inhaled particulates play a role in the anatomical and functional status of the lung.

In view of the above, a framework of some considerations is presented, with the hope that it may be useful to the physician confronted with the diagnosis of a pneumoconiosis. It is recognized that many of the considerations are part of the general survey of a patient, while others may require the assistance of specialized consultants. The framework is as follows.

The Particulates

(Collected from the Atmosphere at the Breathing Level of the Exposed Subject)

1. Judgment as to whether the particulates originate from the general atmosphere vs. that from occupational situations.
2. Physical character of the pollutant:
    a. Size distribution, especially those within respirable range, usually less than 10 microns in diameter for spherical particles.
    b. Density of particles.
    c. Surface area.
    d. Capacity to adsorb and/or absorb other atmospheric constituents.
    e. Shape: spherical or elongated.
    f. Hardness and sharpness.
    g. Radioactive properties.
3. Chemical nature:
    a. Pure or mixed.
    b. Solubility vs. insolubility.
    c. Acidity or alkalinity.
    d. Reactivity: oxidation, reduction, formation of other substances while suspended in atmosphere.
4. Biologic activity:
    a. Animal vs. man.
    b. Target tissue.
    c. Local or systemic.
    d. Toxic vs. non-toxic.
5. Atmospheric concentration: a consideration which operates to determine, in part, the pulmonary concentration in unit period of time; host factors also play a role.
6. Threshold Limit Values: the hazardous atmospheric concentrations have been prescribed for many particulate substances.

The Exposed Subject

1. Subjective findings:
    a. Occupational history; detailed for lifetime worked: when, where, how and dura-

VORWALD

AUTHOR

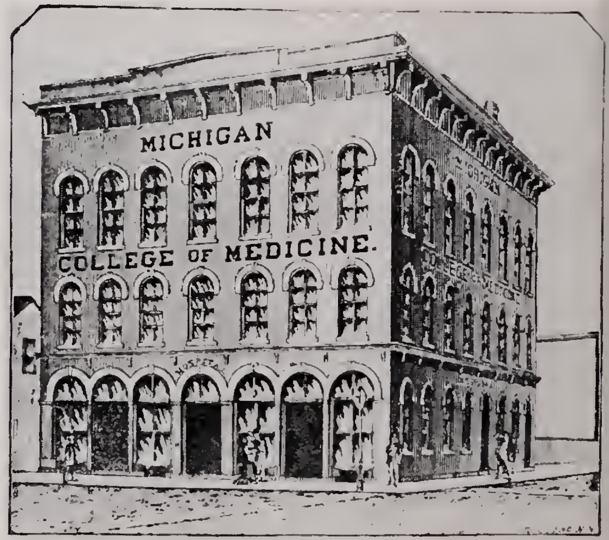
Doctor Vorwald is Professor and Chairman, Department of Occupational and Environmental Health, Wayne State University School of Medicine.

tion; exposure: when, where, how and for how long.
b. Social history: smoking, alcohol.
c. Detailed medical history: familial and personal.
d. Present medical complaints: onset and duration.
e. Time relationships between the above.

2. Objective findings:
    a. General health status for detection of abnormality which may or may not have reference to the inhaled particulates.
    b. Detailed physical examination, not only of the chest, but of the entire body.
    c. Chest fluoroscopy and roentgenography, especially as they may pertain to serial studies made periodically prior to, concurrent with, subsequent to the exposure and at the time of examination. Every technical advantage should be employed to attain the best possible roentgen visualization with a maximum of blurring and with a suitable level of contrast and density which will clearly depict the details in the lung fields.
    d. Laboratory studies: certain procedures are helpful in evaluating a diagnosis, especially in relation to a pneumoconiosis and in establishing the presence of a complicating disease.
    e. Electrocardiogram: in a certain percentage of cases, it may be helpful for the support of a diagnosis of cor-pulmonale or right ventricular strain possibly imposed by increased intrapulmonary tension which may attend a pneumoconiosis. The study is important in all patients with dyspnea.
    f. Cardiopulmonary function: certain pneumoconioses are characterized by functional impairments of the lung. Often, detailed studies are required for qualitative and quantitative evaluation.
    g. Pulmonary biopsy which is representative of the diseased area, which anatomically is guided by the suspected diagnosis and which is sufficient not only for histopathology, but also for chemical analysis.

The criteria deemed essential for the diagnosis of a pneumoconiosis may be stated as follows: 1) there must be history and unequivocal evidence of exposure to the inhalation of particulates with awareness that some particulates are biologically inert and non-toxic, while others are active and toxic, and that pulmonary concentration and retention are important issues; 2) the medical history and complaints should be consistent with the time and duration of exposure and with the known toxicity of the particulates involved; 3) the objective medical findings have to be compatible with the histories of exposure and of illness and with the medical complaints. Finally, the diagnostic considerations include a mindfulness of the fact that the exposed individual is not immune to cardiopulmonary impairments which also afflict subjects of the general population and which may have no causal and/or aggravative relationships to the exposure.

Another WSU Photo From Yesteryear



The Michigan College of Medicine, at St. Antoine and Catherine, was started in 1879 and merged in 1885 with the Detroit College of Medicine, and became in 1913 the Detroit College of Medicine and Surgery.

Pneumonias Caused by Gram-Negative Bacilli

BY A. MARTIN LERNER, M.D.
JAMES R. TILLOTSON, M.D.
BOTH OF DETROIT

The work was aided by a grant (5 T1 AI261) from the National Institutes of Health.

In 1963 it was noted that pneumonias were occurring which seemed to be caused by gram-negative bacilli which had been thought uncertain or, perhaps, rare determinants of disease of the lower respiratory tract.[1]

Since these "unusual" respiratory bacilli appeared repeatedly in sputa, empyema fluids, or bloods and in pure culture or as the predominant organisms; and, moreover, since prior administration of antibiotics which might have induced such a flora had not been given; and, finally, since standard sources were not helpful in predicting clinical courses in the affected patients; further data were collected. Half of these afflicted reached the Stygian shore, and the pneumonias seemed new "captain (s) of the men of death."[2]

It was posed that as with pneumoccal or Friedländer pneumonias these "unusual" pulmonary pathogens, because of their intrinsic biological and biochemical individuality,[3] should occur in favorable clinical milieu and produce characteristic illness. With definition, this has proved true.

The diagnoses of *Escherichia coli,* pseudomonas, proteus, bacteroides, or hemophilus pneumonias were made in 53 patients who were seen during a period of 30 months from July, 1963 through December, 1965 at Detroit General Hospital.

IN EACH, A GRAM-NEGATIVE bacillus had been recovered from 2 or more consecutive sputa or isolated from sputum and blood, both specimens having been obtained on the same day. Similarly the bacterium might have been recovered from sputum or blood and pleural fluid. When a concomitant bacteremia had not been confirmed, improvement after addition of an antibiotic which was effective against the implicated gram-negative bacillus, was accepted as a diagnostic aid. When the courses of the patients were not completely compatible, the case was excluded from the series.

THE GROUP WERE persons in their later middle years (mean age, 53). Moderate to severe chronic disease of the lung (bronchitis, bronchiectasis, emphysema, or asthma) was important in aspirations of oropharyngeal contents and subsequent pseudomonas, proteus, hemophilus and most of the bacteroides pneumonias. These bronchial embolisms of bacteria and mucus tended to lodge and subsequently involve posterior segments of upper and apical segments of the lower lobes.[4]

Heavy cigarette smoking was usual in these pneumonic patients with chronic lung disease. Alcoholism and convulsive disorders, conditions altering the state of consciousness, favored aspiration, and were commonly noted.

Most patients acquired their infections outside of the hospital and were not receiving antibiotics at the times they became ill.

Other patients had normal lungs. Notably these pneumonias were due to *Escherichia coli* or bacteroides. Bacteremias preceded the pneumonias which usually affected lower lobes. "Colon baccillus" pneumonia occurred in patients with urinary tract infections (often with diabetes mellitus). Others with *E. coli* pneumonia had gastrointestinal infections or bowel surgery facilitating bacteremia. Women with pelvic conditions (e.g., tubo-ovarian abscess, postpartum endometritis, induced abortion) developed bacteroides, bacteremia and pneumonia.

Unlike pneumococcal but similar to Friedländer's pneumonias, *Herpes labialis* did not accompany these unusual gram-negative pneumonias. Hospitalizations were protracted (often 6 weeks or more) and management difficult.

Escherichia coli (see table) pneumonias were most frequent of the "captains" (20/53, 37.8%). They were lower-lobe bronchopneumonias; empyemas often developed about the 6th day in the hospital.[5] Multiple resistances to antibiotics were commonplace. Although its use often had to be prolonged and fraught with dangers of oto- or nephrotoxicity, kanamycin was the most uniformly effective antibiotic. In fatal cases (12/20, 60%) interstitial pneumonias with mixed cellular infiltrates, engorgement of capillaries, and edema within and deposition of fibrin along the alveolar walls were usual.

BACTEROIDES PNEUMONIAS followed bacteremias (3/11) or aspirations (5/11). Bacteremias were the result of anaerobic infections in the

CLINICAL FINDINGS IN ADULTS WITH PRIMARY GRAM-NEGATIVE PNEUMONIAS

BACTERIA	PATIENT	PREDISPOSING CONDITIONS OR CHRONIC DISEASES					PATHOGENESIS ASPIRATION (A) OR BACTEREMIA (B)	CLINICAL	THERAPY OF CHOICE, 1967
		LUNG	HEART	PYELONEPHRITIS	DIABETES MELLITUS	OTHER			
1) **Escherichia coli**	Middle-aged, 12/20 men (mean,53 yrs)	—*	±	+	+	Often have gastrointestinal infection or surgery	B	Lower lobe bronchopneumonias with metapneumonic empyemas	Kanamycin, 10-15 mg/kg/24hrs. (total dosage not to exceed 12-15 gm)
2) Pseudomonas	Elderly men (mean,59 yrs)	+	±	—	±	None	A	Nodular lower lobe pneumonias with coalescing microabcesses (cyanosis, confusion, relative bradycardia, reversal of diurnal temperature curve, azotemia, abnormal liver function)	Polymyxins (3-5 mg/kg/24 hrs); Gentamicin (2.4 mg/kg/24 hrs)
3) Proteus	Middle-aged to elderly mean,59 yrs)	+	±	—	±	Alcoholism frequent; (altered state of consciousness (e.g., delirium tremens, coma, . . .) predisposes to aspiration	A	Dense lobar pneumonia with multiple abscesses	Kanamycin (see **E. coli**); Penicillin G or Ampicillin for strains of **P. mirabilis**
4) Bacteroides	Women with pelvic infections	—	—	—	—	Acute or subacute pelvic infections	B	—acute illnesses Lower lobe bronchopneumonias, with empyema, sometimes with abscess	Correction of pelvic condition (often surgery) plus thoracenteses or thoracotomy with tube drainage plus antibiotics
	Middle-aged, predominantly male mean,54 yrs)	+	±	—	—	Alcoholism common, carcinoma of colon	A/B	—subacute illnesses Lower lobe bronchopneumonias, with large rapidly recurring empyemas	Thoracotomy with tube drainage plus antibiotics: Penicillin (aqueous) (10-20,000/U/24 hrs. I.V.) or Tetracycline, (1-1.5 gm/24 hrs. I.V.)
5) Hemophilus influenzae A. Segmental	Infants, occasionally children, rarely adults	—	—	—	—	Infection with type b in persons without circulating bactericidal antibody	A	Lobar pneumonias indistinguishable from pneumococcal pneumonias	Ampicillin (30 mg/kg/24 hrs, I.M.); Tetracycline (12 mg/kg/24 hrs, I.M.)
B. Bronchopneumonias	Middle-aged persons, ⅔ men	+	—	—	—	Infection with any of smooth or rough forms	A	Diffuse miliary bronchopneumonias	

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* **Code:** +, usually present; —, usually absent; ±, sometimes present

pelvis of young or middle-aged women with normal lungs. The rest of these putrid pneumonias occurred in elderly men with significant chronic pulmonary disease.[6] Both groups had bronchopneumonias and early empyemas. Following bacteremia, abscesses in the affected lungs and a more hectic illness were common, while larger and rapidly reaccumulating empyemas were characteristic of the rest. These bronchopneumonias with prepneumonic and often massive empyemas are reminiscent of beta-hemolytic streptococcus pneumonias.[7] At microscopical study of the fatal cases, bacteroides pneumonias were patchy intra-alveolar and interstitial mononuclear infiltrates. Nonetheless, exudates of the empyemas were polymorphonuclear. Surgical correction of pathology within the pelvis, thoracentesis, or thoracotomy with tube drainage and tetracycline were all effective and necessary modalities. Tetracycline was used intravenously at a dosage of not greater than 1.0-1.5 grams per day.

Infection with pseudomonas occurred in patients with more severe chronic lung disease than that of the other gram-negative bacillary pneumonias; of these 10 patients, 8 died. Pseudomonas pneumonias were diffuse nodular infiltrates forming coalescing cystic abscesses reminiscent of staphylococcal bronchopneumonia.[8, 9] Cyanosis, confusion, relative bradycardia, reversal of the diurnal peaks in fever, azotemia, and hepatic malfunction punctuated these maladies. At autopsy, microabscesses and focal hemorrhage within affected areas of the lung were evident.

Unlike fatal cases of pseudomonas bacteremias in which the lungs may be secondarily colonized, pulmonary vessels were patent and their media devoid of a necrotizing bacillary vasculitis. Severe toxicity and aberrant functioning of the liver and kidney, as well as focal polymorphonuclear accumulations within these organs at death, may well have been induced by circulation of several toxic enzymes elaborated by pseudomonas; namely, elastase, hemolysin, lecithinase, and lipase. Polymyxin B (1.5—2.5 mg/kg/day) or E (colistin, 3-5 mg/kg) or gentamicin (2.4 mg/kg) [10] are required, but, nonetheless, most patients died.

PROTEUS PNEUMONIAS occurred in 6 severe alcoholics with moderate chronic lung disease. All contracted pneumonias following periods of stupor or delirium. They were dense lobar consolidations with multiple abscesses. Kanamycin again was the drug of choice.[11]

Hemophilus, like pneumococcal pneumonias in children, are segmental or lobar infiltrates. Increasingly common, however, are diffuse miliary bronchopneumonias in middle-aged or elderly persons with underlying diseases of the lung.[12] Hemophilus pneumonias in adults are benign and may be caused by typable (smooth) or non-typable (rough) stains. Intrathoracic complications are

LERNER

CO-AUTHORS

Doctor Lerner is Professor of Medicine and Associate in Microbiology and Pathology, Wayne State University; Chief of Infectious Diseases and Director, Bacteriology Laboratory, Detroit General Hospital.

Doctor Tillotson performed during tenure as Trainee in Infectious Diseases and Fellow in Medicine, Wayne State University School of Medicine (presently: Instructor in Medicine, Harvard Medical School; Research Associate, Thorndike Memorial Laboratory; and Clinical Assistant, II & IV (Harvard) Medical Services, Boston City Hospital, Boston, Mass.)

TILLOTSON

rare. They respond promptly to moderate administrations of ampicillin or any of the tetracyclines.

Gram-negative bacillary pneumonias occur today and seem to be increasingly frequent. Recognition of their distinguishing qualities allows application, however difficult, of appropriate therapy, and offers the only hope of a sanguine outcome.

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This old photo from the WSU files shows students of the Detroit College of Medicine in 1898 watching an operation in the operating room of St. Mary's Hospital, now Detroit Memorial.

Photosensitizing Drugs, Plants and Chemicals

BY DONALD J. BIRMINGHAM, M.D.
DETROIT

Sunlight is one of nature's most exhilarating attractions. Thousands seek out its rays as a means of relaxing and improving their physical well being and even greater numbers fanatically pursue the sun for the expressed purpose of acquiring the coveted emblematic tan. Sunburn is a frequently experienced by-product of this mania and among those with a feeble tanning mechanism, freckling becomes their only naturally manufactured tan.

It is now common knowledge that a poor tolerance to sunlight leads to premature aging of the skin, the development of actinic keratoses and later cutaneous cancers on the sites of repeated sun exposure. Besides these frequently observed actinic effects upon skin, there is an extremely unique but less commonly occurring group ot reactions due to the phenomenon of photosensitization.

BASIC CAUSAL FACTORS in some of the photosensitivity disorders arise from genetic, nutritional or metabolic aberrations while other photosensitivity effects stem from contact with one or more of a growing list of chemicals, plants and drugs which potentiate the action of sunlight. It is the latter group which is the basis of this review.

Cutaneous photosensitivity caused by certain photoreactive plants was recognized long ago. Later, dyes as Eosin and others contained in therapeutic agents were found to possess specific photosensitizing qualities on skin. Similarly, several chemicals encountered in the work environment were found to injure the skin in the presence of ultraviolet or sunlight exposures. Much of the present interest in photosensitization has stemmed from the increased frequency of photodermatoses attending the use of several drugs.

Clinical alertness in recognizing these reactions has not only enhanced the reservoir of clinical data, it has led also to technical advances in laboratory diagnosis and research pointed toward better definition of the mechanisms at work. Indeed, there are few areas in dermatology where biologists, chemists, physicists, and clinicians have been better able to pool their talents.

Photosensitization is defined as a process within a cell, tissue or organism which has been acted upon by a substance that renders it sensitive to a particular region of the spectrum to which it was previously insensitive. In other words, wave lengths of light — ordinarily considered as only mildly, if at all, capable of causing a reaction in skin — become extremely active in the presence of a photosensitizer. The potentiator or photoreceptor can be an ingestant, an injectant or a contactant. Whichever the route of entry, there occurs an exaggerated reaction of the skin to sunlight due to the photosensitizer residing in the epidermis. The biological events which culminate in the reaction are not clearly established, but it is assumed that once the photosensitizer absorbs the light there begins an energy transfer within the skin. (Energy may be transferred into heat, molecular excitation, molecular dissociation, fluoresce, phosphorescence or free radicals. A free radical is a molecule with unpaired electrons.)

THE DEGREE OF cutaneous insult depends upon several factors which include the type of photosensitizer, its potency, its concentration, the degree of exposure to light, and the natural tolerance of the individual tc light. What happens at the cellular level may depend upon the particular focal site of the photosensitizer. Recently investigators in England have shown that some photosensitizers remain at the cell membrane while others concentrate within the lysosomes. Thus, they suggest two types of photosensitization: one being due to increased permeability of the cell membrane; the other arising from increased permeability of the lysomal membrane with subsequent release of lytic enzyme. In either case, cell injury or cell death can occur. Several of the photosensitizers are tricyclic in chemical structure and many of them fluoresce. They are activated by their own specific wave lengths of light, usually in the 2800 tc 4300 Å range. Some of the dye materials react to wave lengths in the visible spectrum 3900 to 7900 Å. None of the photosensitizers is actuated by infra red.

Phototoxic versus Photoallergic

Photosensitization reactions can be phototoxic or photoallergic. Those based on phototoxicity are the most frequently observed, being somewhat analogous to cutaneous reactions induced by primary irritants. In other words, any one will react to a phototoxic agent following the initial exposure if sufficient amounts of the photosensitizer and light are present. The combined action of the photosensitizer and the light rays promptly produces a toxic reaction within 24 to 48 hours. The resultant clinical change can be a wheal or pronounced erythema or vesicles or bullae. Varying degrees of hyper- or hypo-pigmentation result.

Photoallergic reactions are much less common than those due to phototoxicity. Further, they have a different pathogenetic mechanism. When a sensitizable individual encounters a photoallergen and sunlight, the immediate effects are not generally observable. The light stimulus acts upon the photoreceptive chemical and brings about a structural change which then imparts to the chemical a pro-allergen capacity. Once this change occurs the altered chemical can combine with protein to form a complete antigen and sensitization ensues. When the sensitized level has reached the optimum peak, usually within an incubation period of 5 to 7 days or more, further exposure to the photosensitizer and sunlight induces a reaction. Time, therefore, is an important difference associated with this photo-effect.

Clinical Features

Clinically, dermatoses due to photoreactions dependent upon chemicals, plants or drugs appear on the exposed areas of the body. Drug induced photodermatoses are usually more extensive than those caused by chemical and plant photoreactors, but this is not unequivocal because extensive contact can occur with chemical agents or plants. Irrespective of the cause, the face; anterior neck (V); dorsal surface of the hands, forearms and lower arms are generally affected. If exposure conditions permit, the back and lower extremities similarly can be involved. The scalp is rarely attacked because hair is a natural protection. Other sites which are spared because of natural protection from sunlight are the upper eyelids and the submental area. Not infrequently the watch band will serve as a protector; whereas the left hand and forearm, as well as the left side of the face and neck, may show intensified effects from exposure while driving an automobile.

Morphologically, the lesions can assume a variety of appearances. They may be mildly or severely erythematous, eczematous, bullous, lichenoid or urticarial. Often the inflammatory and vesicular eruptions eventuate in hyperpigmentation, whereas bullous lesions usually lead to hypo-pigmentation. Both of the pigmentary disturbances can persist for months.

Drugs

Since the mid thirties there has been a steady flow of information on drugs associated with photosensitization. The sulfonamides became established photosensitizers when used topically or systemically. None of them, however, was as reactive as the original product — sulfanilamide. Drugs related to the sulfonamides, notably the sulfonylurea oral antidiabetic agents, have been associated with

BIRMINGHAM

AUTHOR

Doctor Birmingham is with the Department of Dermatology & Syphilology, Wayne State University School of Medicine.

photosensitivity reactions. Both chlorpropamide (Diabinese) and tolbutamide (Orinase) are believed to have induced photoallergic effects. Sulfonamide related drugs used as diuretics similarly have caused photoreaction, for example, both chlorothiazide and hydrochlorothiazide were found to act as allergens.

Numerous photoreactions were reported from several of the phenothiazine derivatives. Phenothiazine was used as an insecticide more than 25 years ago and at that time it caused photosensitivity reactions among the sprayers coming into contact with it. Now there is ample evidence that similar preparations, namely, Thorazine, Sparine, Compazine, among others, are effective photosensitizers. About two years ago there were reports describing bluish-gray pigmentation among psychotic patients receiving high and prolonged dosage of Chlorpromazine. The intense discoloration occurred from the chemical combination of melanin and Chlorpromazine.

Among the antibiotics, Demethylchlorotetracycline (Declomycin) and Griseofulvin have caused photoreactions. More recently there have been many reports of photo-effects from certain antibacterial agents, notably those identified as halogenated salicylanilides. Bisphenol also was found to be an active photosensitizer. The first of these, tetrachlorsalicylanilide, was noted to produce photo-effects among a group of workers in a British factory where the substance was being used in an industrial soap. It was found to also cause contact sensitization. Tribromosalicylamide, used as an antibacterial in soap, has caused similar reactions. Bithionol (Bisphenol) formerly had a wide usage in toilet soaps, shampoos, deodorants, among other cosmetic preparations; but its unexpected behavior as a photosensitizer caused its discontinuance as an antibacterial in cosmetics.

A recently reported photosensitizer is the artificial sweetener — Cyclamate. Its photoreceptive action was first reported in Japan and lately in this country. Chemically, Cyclamate is a sodium or calcium salt of cyclohexylsulfamate. Here, again, is a compound related to the sulfonamide group. In short, there are well over 100 drugs which have become associated with untoward reactions in the presence of sunlight. Many of the photodermatoses due to drugs are believed to be allergic.

Accepted criteria for differentiating between drug photoxicity and photoallergy were proposed by Baer, with certain modifications by Harber:

PHOTOTOXICITY	CRITERION	PHOTOALLERGIC
+	First exposure.	0
0	Incubation period.	+
0	Chemical change in photosensitizer.	+
Sunburn-like.	Clinical changes.	Varied
0	Flares at previously involved distant sites.	+
0	Persistent reaction to light.	+
0	Cross-reactions.	+
High	Concentration of drug required for reaction.	Low
High	Incidence.	Low
Usually similar to absorption spectrum.	Action spectrum.	Usually higher than absorption spectrum.

Although these criteria were set forth as applied to drugs, they can be applied equally well in differentiating between phototoxic and photoallergic reactions due to chemicals or plants.

Plants

Some of the most fruitful research in photosensitivity has come from studying phytophotodermatitis, in general, and the furocoumarins, in particular. Years ago it was noted that eau de Cologne caused hyperpigmentation of the skin. Next it was ascertained that sunlight was a necessary factor. Later it became evident that most plants possessing photoreactive capabilities belonged to the family, Umbelliferae, which includes wild parsnip, cow parsnip, parsley, celery, wild carrot, fennel, and dill.

Today we know that most of the phytophotodermatoses are due to the furocoumarins, notably the psoralens. These materials (psoralens) are extremely potent photoreactors, e.g., bergapten (5-methoxypsoralen) is contained in some colognes; 5- and 8-methoxypsoralen are present in numerous of the plants mentioned. The more active psoralens can be extracted from their plant sources or can be synthesized and then used therapeutically because of their stimulatory action on the melanocytes. Thus, they can be used in treating vitiligo and leukoderma to restore the pigment and in sun sensitive skin to reinforce the protection afforded by melanin.

A few years ago in Michigan complaints of vesicular and bullous dermatitis among the celery harvesters set the stage for a dermatologic study among these employees. It was found that harvesting the normal celery was not attended by any such difficulty; but when contact was made with pink-rot celery (infected by the fungus, sclerotinea sclerotiorum) and sunlight, vesicles and blisters appeared within 36 hours. The phototoxic psoralens contained in the diseased celery are 8-methoxy and trimethyl psoralens — both of which are highly potent. Among the plants reported to cause photodermatoses are:

Agrimony
Angelica
Blind Weed
Buttercup
Celery (Pink-Rot)
Common Rue
Dill
Fennel
Fig
Gas Plant
Goose Foot
Lime
Masterwort
Mustard
Parsley
Parsnip (Cow, Garden, Wild)
Persian Lime
St. John's Wort

(With modifications, per Pathak, Daniels and Fitzpatrick, J. Invest. Dermat. 39: 225-239, 1962)

Chemicals

A number of occupations are associated with hyperpigmentation of the skin. Men employed in coal tar distillation plants encounter anthracene, acridine and phenanthrene — all of which are known photosensitizers. Creosote impregnation of wood to be used for railroad ties, telephone poles, fence posts, etc., is attended by hyperpigmentation and exaggerated effects of exposure to sunlight. Coal tar pitch, paints, roofing pitch, and road tar have many applications and similarly effect many workmen. Pipe line installations cause extreme melanoderma among many of the workmen from the tar products used to weatherproof the pipe line. Workmen changing the lining of certain industrial furnaces have developed burning, itching and melanoderma of the face, neck and hands from contact with tar dust present in the linings and then subsequent exposure to sunlight.

Some chlorinated hydrocarbons, notably the chlorobenzols, chlorinated di- and tri-phenyls, and the triphenyloxides — besides causing chloracne — produce a peculiar grayish pigmentation of the light exposed areas. The number of photosensitizing chemicals encountered in industry is small when compared to the general list of chemicals contained within the work environment, but when compounded with possible exposure to photosensitizing drugs the problem is one of increasing importance.

Photosensitizing Chemicals

Acridine
Anthracene
Benzene
Chlorobenzodioxanes
Chlorobenzols
Chlorodiphenyloxides
Chlorodiphenyls
Chlorotriphenyls
Chloronaphthalenes
Coal Tar and Distillates
Coal Tar Paints
Coal Tar Pitch
Creosote
Phenanthrene
Road Tar
Roof Pitch

Summary

It is of advantage for the physician to be aware of the potential interaction of certain drugs, plants, chemicals and sunlight. Photosensitization reactions are being clinically recognized with increasing frequency. They can be phototoxic or photoallergic in nature, but most photoreactions are phototoxic. The photoallergic reactions are relatively uncommon. The photoallergic eruptions caused by contact can be diagnosed with photopatch testing techniques.

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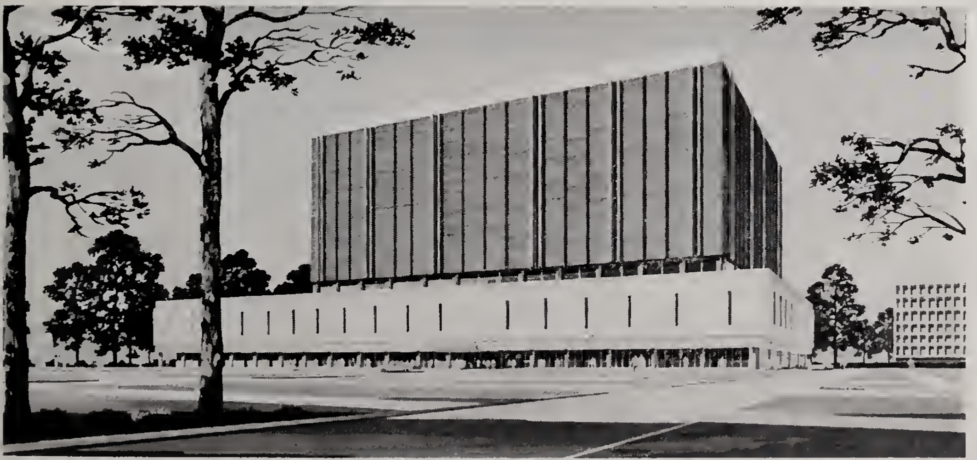

The eight-story, new WSU Basic Science Building will be located just west of the Medical Research Building. Upon completion, the new teaching facility will allow an increase in the entering class of medical students from 130 to 200.

The Spectrum of Autonomous Function In Thyroid Nodules

BY JOEL I. HAMBURGER, M.D.
SOLOMON C. WERCH, M.D.
GEORGE KADIAN, M.D.
HERBERT W. ROSSIN, M.D.
ALL OF WAYNE COUNTY

Scanning with radioiodine has contributed to the formulation of a classification of thyroid nodules in terms of their capacity to concentrate this tracer substance. Thyroid nodules which concentrate 131-I to a greater degree than extranodular tissue have been called "hot" nodules.[1] "Hot" nodules, however, may arise as a consequence of many different pathophysiologic processes.[2] Of these processes autonomous function, function independent of extrathyroidal stimulating factors, has been the subject of considerable attention in the medical literature.[3-5]

Most of this literature has dealt with radioisotope techniques for the demonstration of those "hot" nodules which function autonomously. Thyroid nodules of activity similar to that of extranodular tissue ("warm") may also have autonomous function.[6] Despite the fact that the suppression scan (a scan following thyroid hormone administration) has been shown to be of value in the diagnosis of "warm" autonomous nodules, this clinical test, unfortunately, has only rarely been employed. Data on the incidence of autonomous function in thyroid nodules is unavailable in the medical literature since there has been no systematic application of appropriate confirmatory tests in any sizeable series of consecutive patients suspected of having autonomous nodules.

Our experience over a period of five years (1961-1966) with a population of 3088 referred, private patients helped further our understanding of autonomous function in thyroid nodules. We believe that this experience adds to the literature in three ways:

1. It contributes a reasonable value for the incidence of autonomous nodules in all thyroid patients, and especially in those with discrete nodules;
2. It emphasizes the importance of suppression scanning in the identification of autonomous "warm" nodules;
3. It demonstrates the pictorial spectrum of the autonomous nodule.

Material and Methods

The autonomous thyroid nodules studied were selected from 3088 private patients referred to a thyroid diagnostic laboratory over a five-year period between 1961 and 1966. During this period, patients with discrete nodules (at least 1 cm. in frontal and antero-posterior projection), were scanned routinely. The distinction by physical examination between true nodularity and accentuation of the normal lobular architecture of the thyroid is admittedly difficult in some instances. Since we wished to uncover all patients with autonomous nodular function, all the discrete thyroid protruberances were accepted for study. Patients with multinodular and irregular goiters were not included in this study unless one or more discrete nodules could clearly be distinguished from the main mass of the goiter.

Preliminary scanning permitted the nodules to be divided into three groups:

1. "Cold" nodules; those with less activity than that of the extranodular thyroid tissue.
2. "Warm" nodules; those with activity similar to that of the extranodular thyroid tissue.
3. "Hot" nodules; those fulfilling the criterion of Perlmutter,[7] having 125% of the activity of the symmetrical contralateral area of the gland.

Attention should be called, at this point, to the potential error in the assumption that activity recorded in the area of the scan in which a nodule is localized actually results from radioactivity emanating from that nodule. A cuff of normal tissue in front of or behind the nodule may give a functionless nodule the appearance of being active. Hence the classification on the basis of the preliminary scan was always considered presumptive. In particular small nodules which localized to areas of function similar to that of extranodular tissue, and hence were classified as "warm," might actually have been nonfunctional. Conventional scanning classifications permit no solution to this dilemma. At this point we chose to follow the standard classification, recognizing its limitations, to permit comparison of our data with that of others. Some nodules fulfilling the criterion for "hot" nodules were excluded from the study be-

TABLE I

Incidence of Autonomous Function in 424 Discrete Thyroid Nodules in 3088 Consecutive Private Referred Patients

Type of Nodule	Number			%
"Cold" Nodules	263			
"Warm" Nodules	105			
a. Incompletely Studied		62		
b. Completely Studied		43		
1) Suppressible			30	
2) Autonomous			13	38*
"Hot" Nodules	56			
a. Incompletely Studied		22		
b. Completely Studied		34		
1) Suppressible			10	
2) Autonomous			24	70*
a) With Hyperthyroidism			10	
b) Without Hyperthyroidism			14	
Total confirmed autonomous nodules			37	48**

*Percent of those completely studied

**Percent of "warm" and "hot" nodules completely studied

cause they were obviously examples of compensatory hyperplasia secondary to previous contralateral surgery, or were associated with Graves' disease. Patients with nodules which on preliminary scan were either "warm" or "hot," unless contraindicated, were advised to have additional confirmatory scanning procedures of the following types:

1. If the preliminary scan revealed a "hot" nodule with relatively complete suppression of extranodular function, a repeat scan was done after stimulation with intramuscular TSH (five units daily for two days). The "lighting up" of the contralateral lobe seen on a repeat scan was considered confirmatory evidence for the presence of an autonomous "hot" nodule.[2]
2. If the preliminary scan revealed a "hot" nodule with considerable extranodular function, or a "warm" nodule, then a repeat scan was done after suppression with oral L-thyroxine (0.3 mg. daily for four weeks). The four-

CO-AUTHOR

HAMBURGER

ABSTRACT — Evaluation of 3088 referred, private thyroid patients showed that among 424 with discrete nodules, 161 patients had either "warm" or "hot" nodules. Confirmatory data, including suppression scanning, from 77 of these 161 patients revealed autonomous function in 37, or 84% of "warm" and "hot" nodules, and at least 9% of all nodules. Scanning provided pictorial confirmation of autonomous function in nodules ranging from large, "hot" with hyperthyroidism, to occult, "warm" and asymptomatic. Asymptomatic autonomous nodules were observed without treatment, and provided data supporting the concept that autonomous "hot" nodules producing hyperthyroidism evolve from autonomous nodules with lesser degrees of function.

> week period serves both to permit decay of the initial tracer dose, and to suppress pituitary release of TSH. If the repeat scan revealed persistent 131-I concentration in the area of the nodule, with suppression of 131-I concentration by extranodular tissue, then the diagnosis of an autonomous nodule was considered confirmed.[2]

The suppression scan was done with caution in patients over 50 years of age, and was contraindicated in those with cardiac arrhythmia, congestive heart failure, angina pectoris or patients over 65 years of age.

Results

The types of nodules encountered are presented in Table 1 according to scanning and physiologic criteria. Discrete nodules were found in 424 patients. Among these, 263 were "cold" and were not studied further. "Warm" nodules were found in 105 patients. Suppression scans were done in 43 instances and 13 autonomous "warm" nodules were uncovered. "Hot" nodules were found in 56 patients. In 34 of these patients confirmatory scanning was done, and autonomous function discovered in 24, of whom 10 had manifestations of clinical hyperthyroidism.

Autonomous function was confirmed in a total of 37 of 424 discrete nodules for an incidence of 9%. If the same proportion of patients not tested, as those tested, proved to have autonomous function the true incidence of autonomous function would have been higher, about 13%. The incidence of confirmed autonomously functioning nodules in the entire group of 3088 patients was slightly in excess of 1%. Once again assuming that autonomous function was present in the same proportion of patients not tested, as those tested, the probable incidence of autonomously functioning thyroid nodules that may be encountered in thyroid patients in general would approach 2%.

There were 10 patients with toxic autonomous "hot" nodules. Although 24-hour 131-I uptakes were frequently within normal limits, the PBI determinations gave values above 7Ug% in all instances. Those with lower PBI values had less obvious manifestations of hyperthyroidism. These patients ranged in age from 33 to 68 years with a mean of 54 years. Only one patient was under 40 years of age.

The nodules ranged in greatest diameter from 1.5 cm. to 8 cm. with a mean of 4 cm. The only patient which had a nodule less than 3 cm. in diameter actually had three nodules, each of which measured 1.5 cm. in diameter.

There were 14 euthyroid patients with autonomous "hot" nodules. The lesser function of these nodules, compared with the previous group, was associated with lower values on both the 24-hour 131-I uptake and the PBI determination. These patients ranged in age from 22 to 65 years, with a mean of 48 years. Five of these patients were less than 40 years of age. These nodules ranged in greatest diameter from 1.5 cm. to 3.5 cm., with a mean of 2.5 cm.

There were 13 patients with autonomous "warm" nodules. All were euthyroid on the basis of both clinical and laboratory evaluation. These patients ranged in age from 10 to 62 years, with a mean of 43 years. Five of the 13 patients were less than 40 years of age and only one was over 60 years of age. The nodules ranged in greatest diameter from 1.5 to 2.5 cm., with a mean of 2 cm. In 7 patients the nodule was delineated on the preliminary thyroid scan from the distortion of the normal butterfly configuration. In 6 patients the preliminary thyroid scan was normal. Marks placed on the scan on the basis of the physical examination were required to localize the nodule. Suppression scanning confirmed autonomous function in all of these nodules. Extranodular function was obliterated and all residual activity localized to the area of the palpable nodule. The 24-hour 131-I uptake in patients with "warm" nodules after suppression with thyroxine were significantly less than preliminary values. This was attributed to reduction in function of extranodular tissue.

The spectrum of autonomously functioning thyroid nodules is presented in Figures 1-6. The first patient (Figure 1 had an autonomous "hot" nodule with clinical hyperthyroidism treated successfully with 131-I. The second patient (Figure 2) had an autonomous "hot" nodule of similar size, but no manifestations of hyperthyroidism. There is a central "cold" area in this nodule. In our experience "cold" areas in "hot" autonomous nodules represent areas of degeneration. This may account for the failure of this nodule to secrete enough thyroxine to produce hyperthyroidism in spite of its considerable size. The third patient

Continued on Page 50

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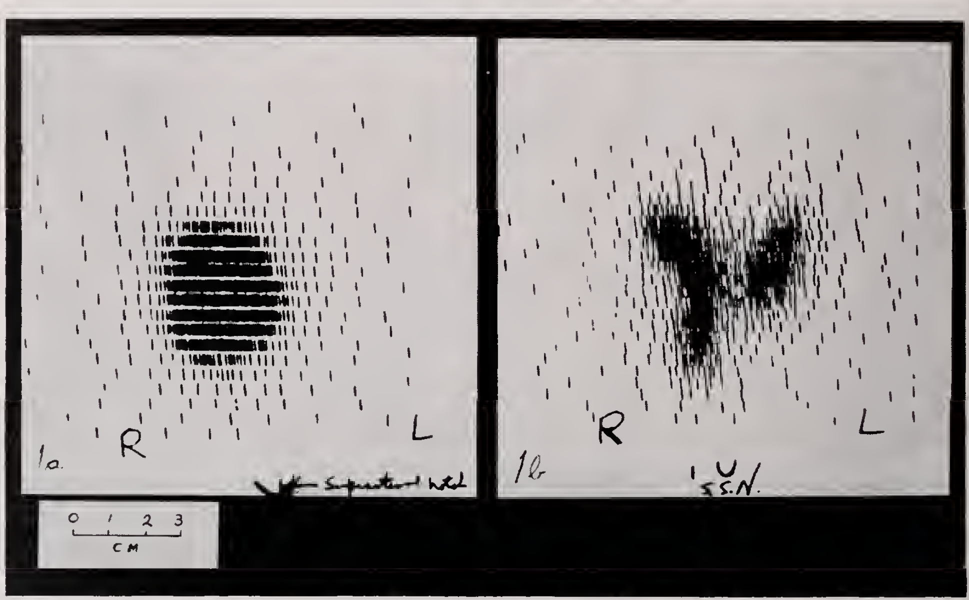
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1a.
Suprasternal notch
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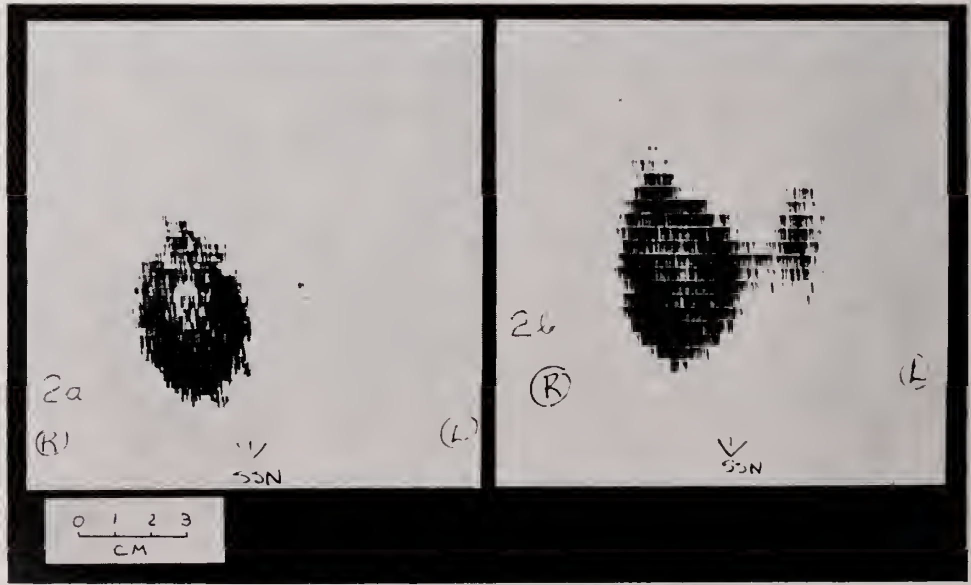
CM
R
L
1b
S.S.N.

Figure 1: L. T., Hyperthyroid woman. a. 24-hour 131-1 uptake 52%, nonsuppressible. Four cm. "hot" nodule right lobe. b. Three months after 50 mc. 131-1. 24-hour uptake 22%. Butterfly pattern with elongated right lobe indented by smaller, nonfunctional nodule.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(L)
SSN
0 1 2 3
CM
2b
(R)
(L)
SSN

Figure 2: R. F., Euthyroid man. a. 24-hour 131-1 uptake 23%. Four and one-half cm. "hot" nodule right lobe. b. Scan after TSH reveals "lighting up" of the left lobe.

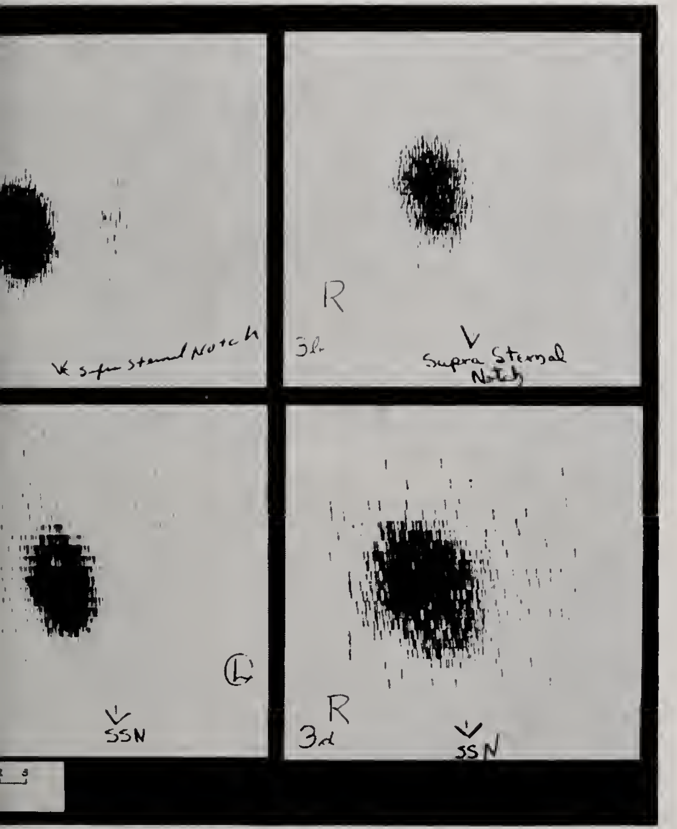
supra sternal Notch
R
3b
V
Supra Sternal Notch
L
SSN
R
3d
SSN

Figure 3: S. E., Euthyroid woman. a. 24-hour 131-1 uptake 22%. Four cm. "hot" nodule right lobe with some persistent function left lobe. b. Uptake on L-thyroxine 24%. Suppression scan, "hot" nodule persists but function of left lobe obliterated. c. Scan 1 year later reveals less function in left lobe than in a. d. Scan 2½ years after initial study reveals enlargement of "hot" nodule to 5 cm. and complete suppression of left lobe function. Patient still euthyroid.

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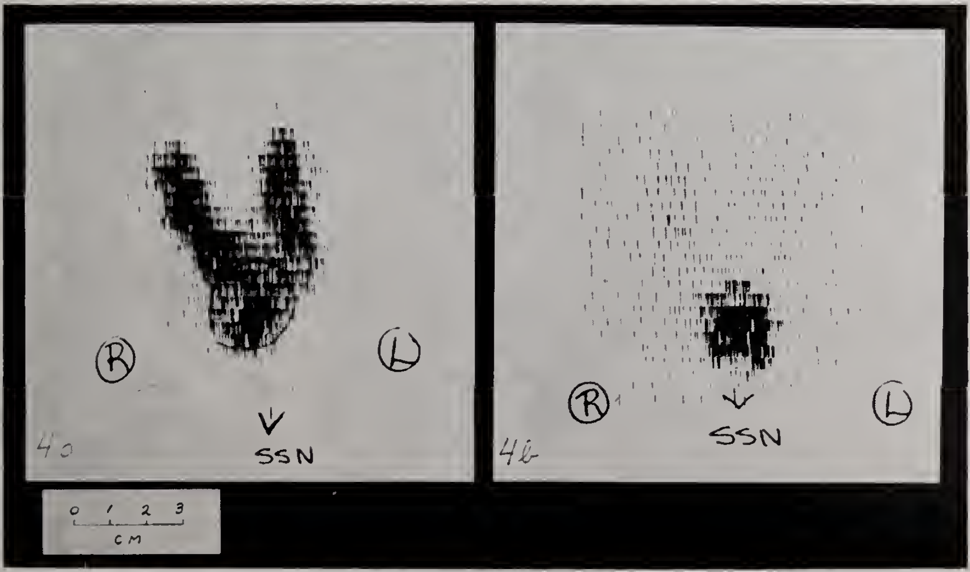
R
L
V
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4a
R
L
SSN
4b
0 1 2 3
CM

Figure 4: C. T., Euthyroid woman. a. 24-hour 131-1 uptake 27%. Two cm. "warm" nodule with function similar to that of the rest of the gland projects inferiorly from the isthmus. b. On L-thyroxine uptake suppressed to 7%. Suppression scan reveals all tracer confined to the nodule.

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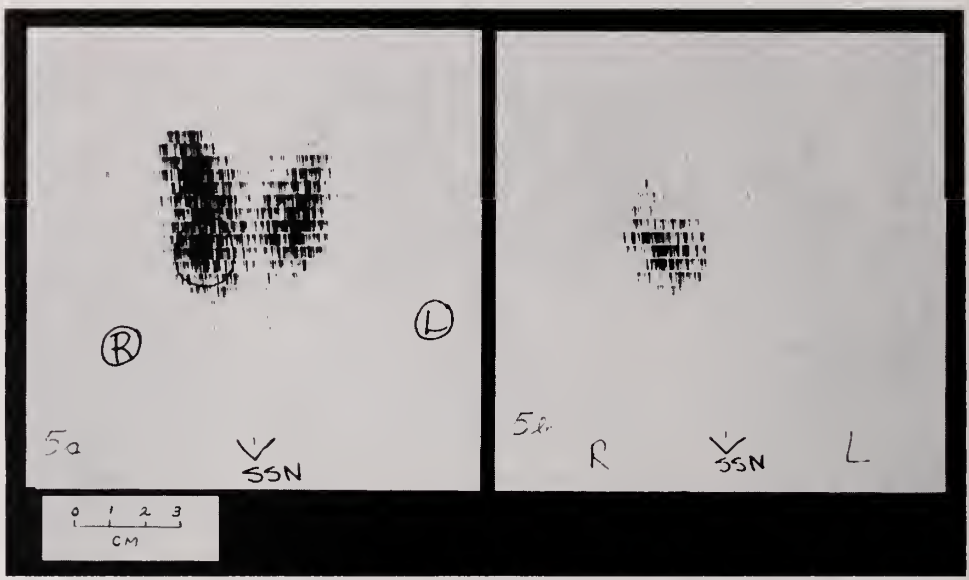

Figure 5: J. T., Euthyroid woman. a. 24-hour 131-1 uptake 24%. "Warm" nodule right lower pole identifiable only by markings on scan. b. On L-thyroxine uptake suppressed to 4%. Suppression scan reveals all tracer confined to the right lobe nodule.

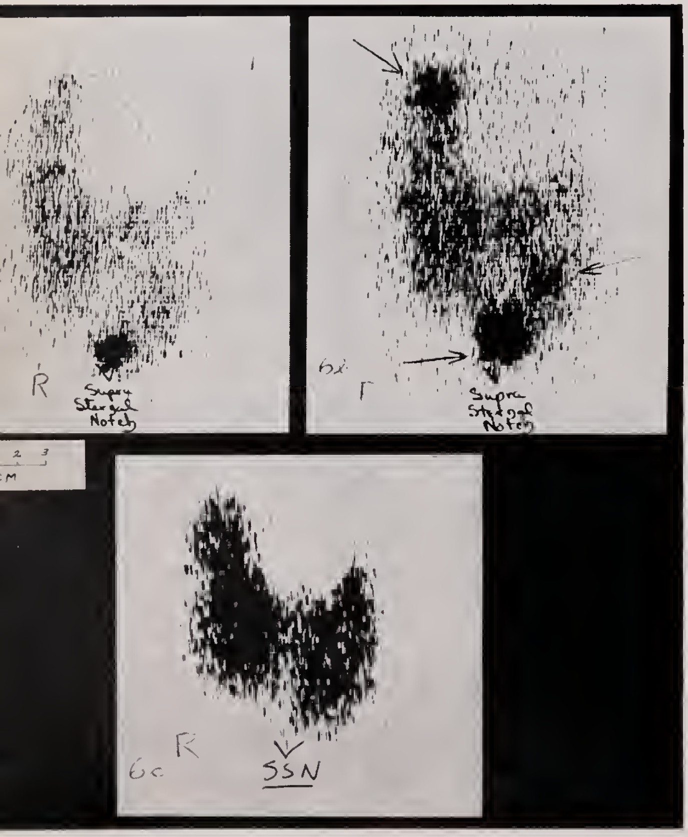

Figure 6: J. P., Woman with paroxysmal tacycardia. a. 24-hour uptake 41%. A large multinodular goiter with a 1.5 cm. "hot" nodule at the suprasternal notch is seen. b. On L-thyroxine the uptake suppressed to 22%. Suppression scan reveals persistent function diffusely with 3 areas of autonomous function (arrows) corresponding to palpable nodules. c. Three months after 30 mc. 131-1 the 24-hour 131-1 uptake is 27%. The scan reveals uniform function in a smaller gland.

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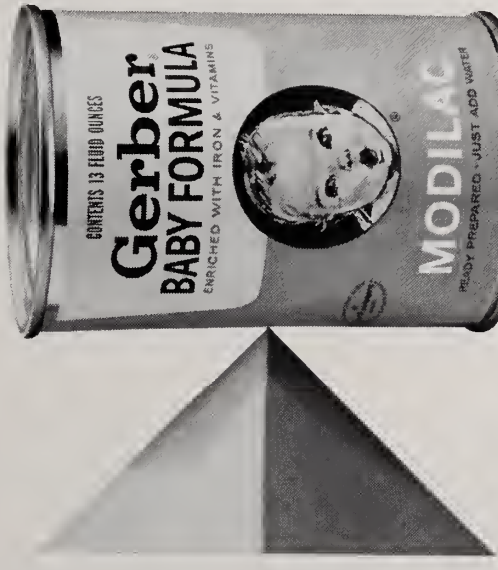
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(Figure 3) has been followed without therapy for almost 3 years. On the initial scan (3a) there is definite function in the contralateral lobe. This was obliterated on the suppression scan (3b). One and one-half years later (3c) there is relatively less contralateral activity in reference to background. Three years later (3d) the nodule has enlarged and contralateral activity is reduced to the level of background. The next 2 patients (Figures 4-5) have progressively smaller and less functional nodules with correspondingly less suppression of extranodular function on preliminary scan. Suppression scan confirms autonomous function in all instances. Patient J. P. (Figure 6) is an unusual example of multiple occult autonomously functioning nodules revealed by suppression scanning.

Discussion

All autonomous "hot" nodules are not associated with hyperthyroidism.[8] It is accepted that all "hot" nodules are not autonomous.[2] Now it must be emphasized that all autonomous nodules are not "hot." In fact, it is possible for an autonomous nodule to present on preliminary scan with function less than that of the extranodular thyroid tissue.[9] The incidence of autonomous nodules reported in this series is in no way comparable to the previously reported incidence of "hot" and/or "warm" nodules. In previous papers confirmatory studies for autonomous function were limited to "hot" nodules or, more often, entirely neglected. Comparative data on the incidence of autonomous nodules is sorely needed. Our data supports a prediction by Myhill, et al,[10] that very few functional ("warm") nodules are autonomous.

When the hormonal secretion of an autonomous nodule is insufficient to cause suppression of extranodular tissue ("warm" autonomous nodules) and there is relatively uniform 131-I concentration throughout the scan, one cannot conclude after inspection of a preliminary scan that the activity, in the area in which the nodule localizes, arises from 131-I concentrated by that nodule. The nodule may be totally nonfunctional and the activity observed could be arising from normal tissue in front of or behind the nodule. The appearance of the scan may not even indicate the presence of a nodule. Suppression scanning is necessary to confirm autonomous function in these "warm" nodules as first shown by Gorowski and Chomicki.[6]

It is of interest that the secretory activity need not correlate with the gross size of the nodule. Some large nodules produce less thyroid hormone than smaller nodules. This may relate to inherent differences in functional activity per unit of tissue mass, or may reflect the frequent observation that large portions of sizeable autonomous nodules may be nonfunctioning degenerated tissue.

Although "warm" autonomous nodules, in our experience, are uniformly asymptomatic, it is important for the clinician to consider the possibility of the existence of occult autonomous function for at least three reasons:

1. Current emphasis on the use of thyroid hormone for the treatment of goiter[11] may lead the unwary physician to precipitate an hyperthyroid state in a patient with nodular goiter and unsuspected autonomous function. The persistent secretion of the autonomous nodule will provide additional thyroid hormone to that administered orally.
2. Autonomous nodules, although asymptomatic when diagnosed, later may cause hyperthyroidism and/or cardiac arrhythmia. Knowledge of the existence of such a nodule will alert the physician to these possibilities.
3. When malignancy is suspected the demonstration of autonomous function will help to allay that concern.

The usefulness of scanning in the preoperative evaluation of thyroid nodules has gained wide acceptance.[12-18] Still there are those who consider scanning "disappointing,"[19] of "limited help,"[20] to provide only "negative information,"[21] and not "absolutely reliable."[22] In a recent paper published from Selenkow's laboratory, outlining a practical approach to the selection of nodular goiter patients for surgery, scanning was not even mentioned.[23]

Those who expected scanning to solve the clinical dilemma of which thyroid nodules should be excised have been disappointed. Nevertheless, scanning thyroid nodules can provide valuable data. Although there is general agreement that cancer usually presents as a "cold" nodule, all "cold" nodules are not malignant. Further evaluation must be clinically based. An hyperfunctional primary thyroid cancer has never been reported, and "hot" nodules are rarely associated with inci-

Continued on Page 65

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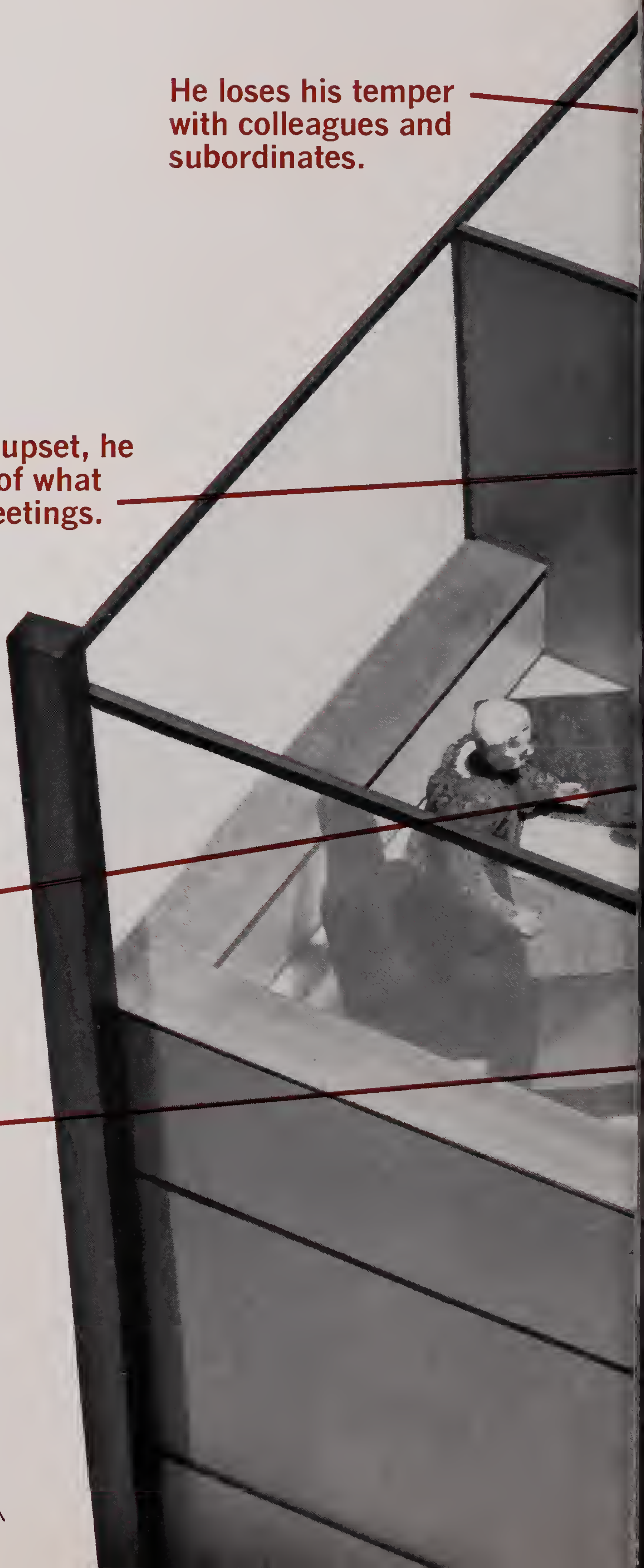

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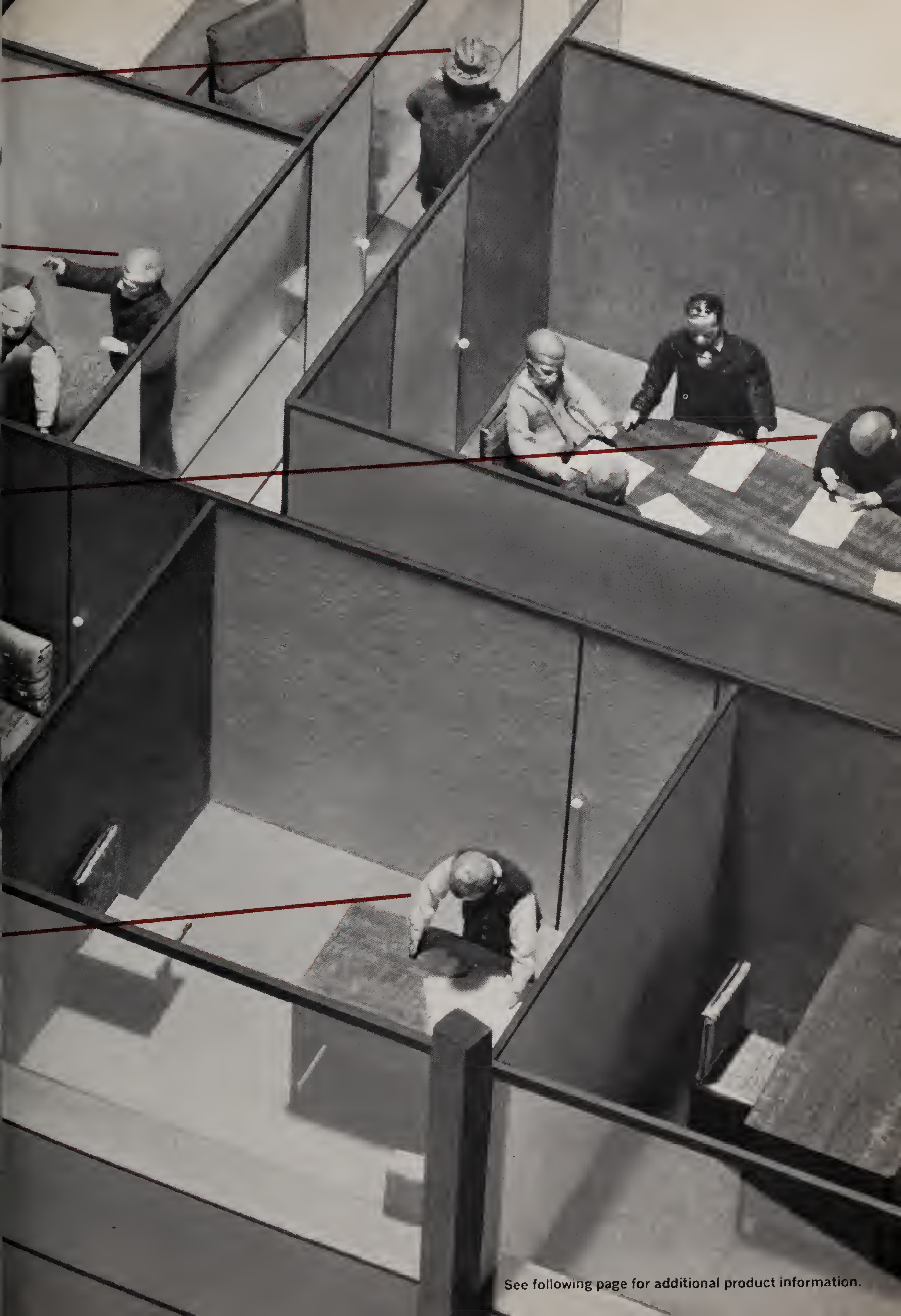

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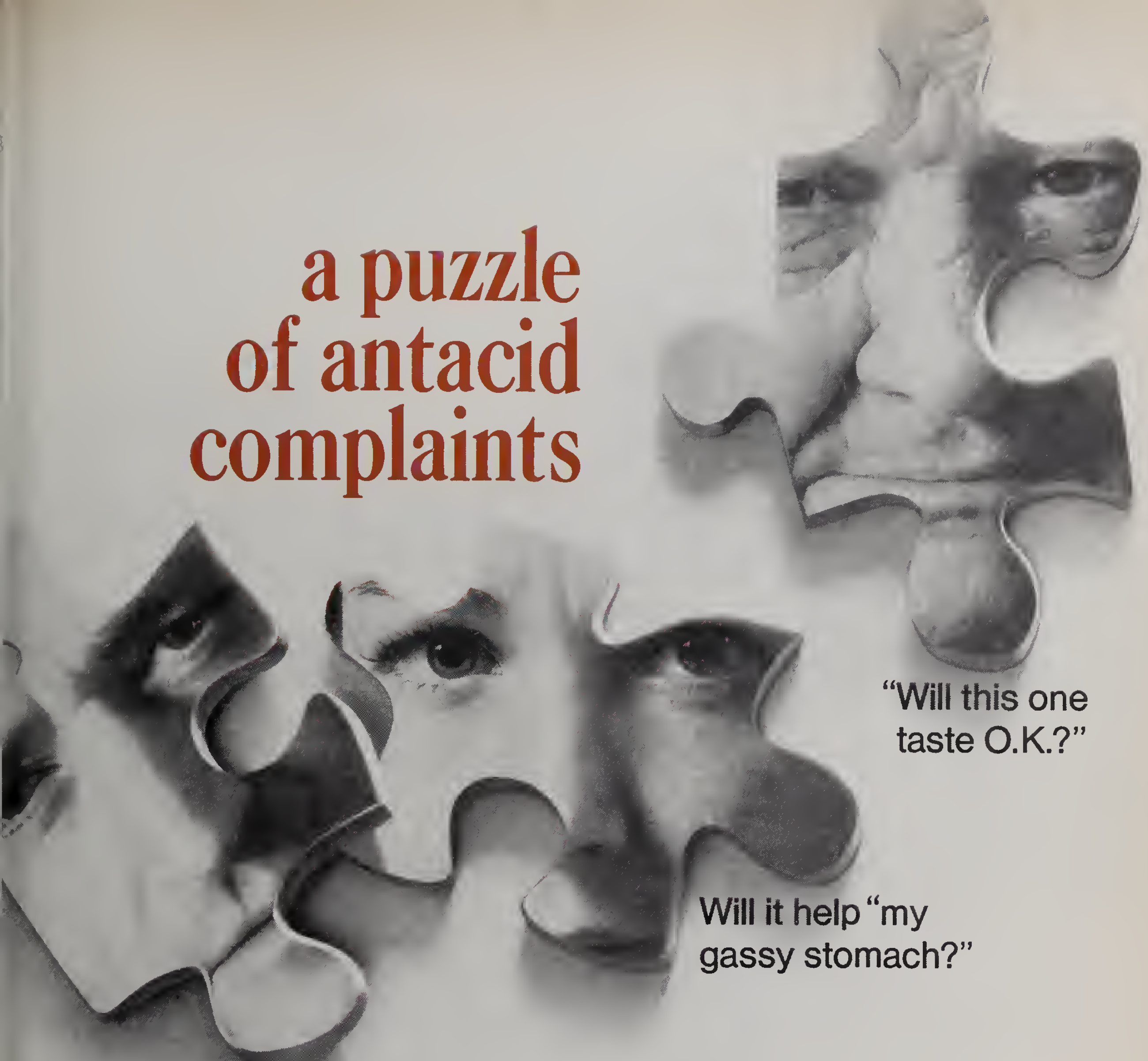
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References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

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(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

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was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

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References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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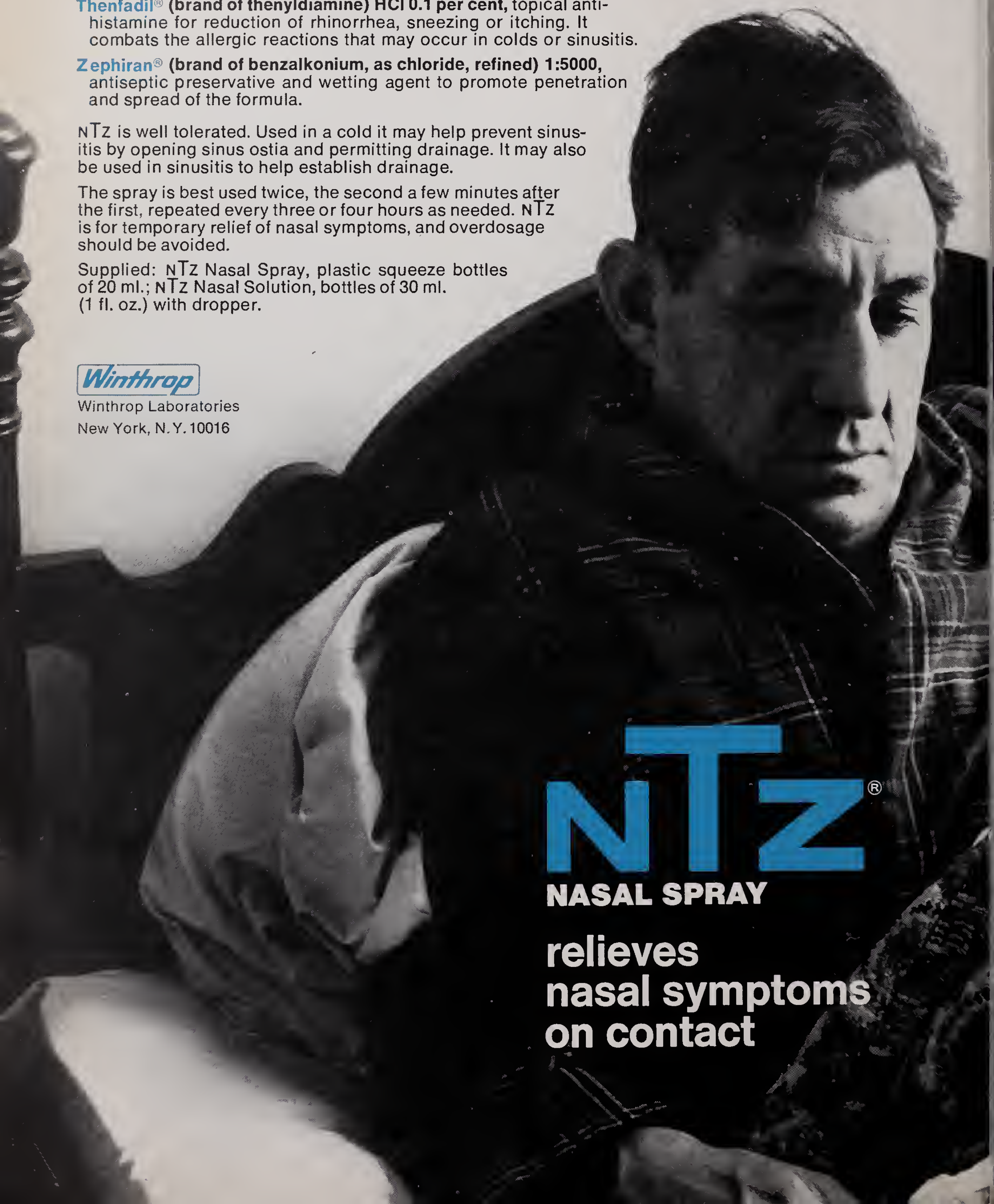
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dental thyroid cancer.[2] Therefore, "hot" nodules are generally considered benign.

"Warm" nodules pose a more complex problem. As already noted, one cannot conclude that activity recorded in the area of the scan in which a "warm" nodule has ben localized actually arises from that nodule rather than adjacent normal tissue. It has been suggested repeatedly that "warm" nodules be given a trial of thyroid hormone treatment and those failing to regress should be removed.[12, 13, 17, 18, 22] However, two basically different types of thyroid nodules which may appear to be "warm" on scanning may not respond to thyroid hormone administrations:

1. Nonfunctional nodules, malignant or otherwise. In these cases the recorded activity actually arises from adjacent normal tissue.
2. Autonomous "warm" nodules whose function is independent of TSH.

Since an autonomously functioning thyroid cancer is yet to be demonstrated there would seem to be no need routinely to remove autonomous thyroid nodules. Of our series of 37 patients with confirmed autonomously functioning nodules, 10 had surgery. None had thyroid cancer. The employment of a suppression scan in the evaluation of "warm" nodules should thus extend the usefulness of both thyroid scanning and thyroid hormone administration as screening measures for malignancy.

Much remains to be learned about autonomous nodules. Of particular interest is the manner in which toxic autonomous nodules arise. Sheline and McCormack suggest that TSH dependent "hot" nodules may "escape from pituitary control" to give rise to toxic autonomous "hot" nodules.[8] In our opinion this concept assigns disproportionate significance to the simple physical phenomenon of iodine concentration. For a nodule to be "hot" on scanning requires only that extranodular tissue concentrate less tracer than the nodule. This may result from extranodular inflammatory disease, degeneration, agenesis or even surgical excision. Since "hot" TSH dependent nodules can arise as a result of such diverse pathological processes it seems inappropriate to consider increased iodine concentration per se as evidence for a fundamental relationship between all "hot" nodules. We believe that the similarity in physiology of nodules with varying degrees of autonomous function is a more acceptable basis upon which to predicate such a fundamental relationship.

Perusal of our data suggests not only that autonomous nodules of varying degrees of function may be related but also that toxic autonomous nodules may arise from autonomous nodules with lesser degrees of function. In support of this concept are the following observations:

1. Autonomous nodules with greater degrees of function generally were larger.
2. Larger and more functional autonomous nodules had a tendency to occur in older patients.
3. In a single patient it has been shown that over a period of 3 years an autonomous nodule enlarged and increased in function. Hence the spectrum of autonomous function here reported would seem to represent a recapitulation of the events in the development of a toxic autonomous nodule.

The failure of others to have observed the sequential changes in the development of toxic autonomous nodules is undoubtedly related to the following considerations:

1. Changes in the functional activity of autonomous nodules occur very slowly. A number of our patients have been followed for up to 4 years without discernible change in function.
2. Definitive therapy has generally been advised for solitary nodules in the past, thus eliminating the possibility of follow-up.
3. Methods to confirm autonomous function have only recently been reported and have not been widely employed.
4. In addition to progressive increase in function autonomous nodules may also undergo degeneration.

More conclusive data on the natural history of autonomous nodules will only be provided by a long-term study requiring the cooperation of all those who deal with nodular goiters.

Summary

Evaluation of 3088 referred, private thyroid patients showed that among 424 with discrete nodules, 161 patients had either "warm" or "hot" nodules. Confirmatory data, including suppression scanning, from 77 of these 161 patients revealed autonomous function in 37, or 48% of "warm"

and "hot" nodules, and at least 9% of all nodules. Scanning provided pictorial confirmation of autonomous function in nodules ranging from large, "hot" with hyperthyroidism, to occult, "warm" and asymptomatic. Asymptomatic autonomous nodules were observed without treatment, and provided data supporting the concept that autonomous "hot" nodules producing hyperthyroidism evolve from autonomous nodules with lesser degrees of function.

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Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with Oracon has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of Oracon usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: Oracon is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on Oracon are available from Mead Johnson Laboratories.

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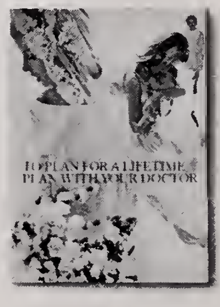
A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.



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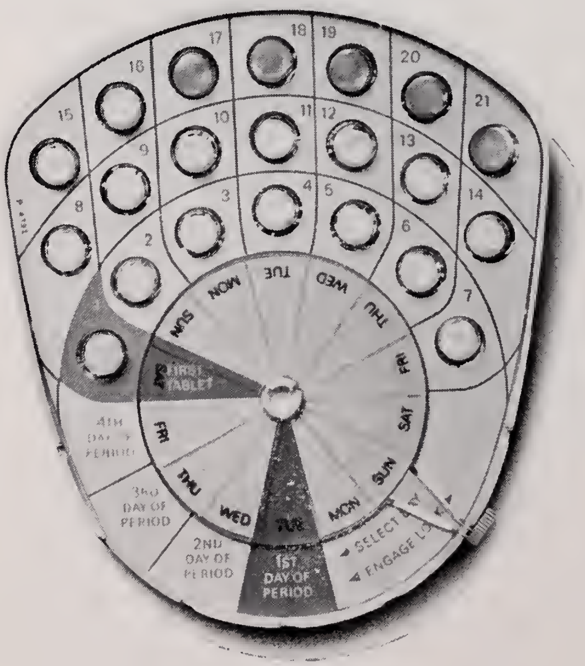

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What is Current Thrust of MSMS In Ethics, Discipline, Standards?

Where does MSMS stand on matters of ethics, discipline, professional qualifications, standards and morals?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS.

The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed the November issue are invited to go back and read it. The November article promised to print parts of the "Where We Stand" publication in future issues.

The first two subjects were reprinted in the December issue and other material will follow.

Discussion

Independent Judiciary Judicial Commission

MSMS established an independent judiciary, as it were, when it altered its bylaws to form the Judicial Commission. It did so because it wanted to place in one body the responsibility for the ethics, discipline, standard (of conduct), and morals of the profession.

Ethical Relations with Osteopaths

The Judicial Commission has felt its way slowly as behooves a deliberative body. It has approached the osteopathic issue from the standpoint of ethical relationships. It has met with the State Board of Registration in Medicine to develop means of solving mutual problems. It has considered numerous matters raised from within the Society.
The Judicial Commission has a long road ahead.

It must develop ways of clarifying:

1. Moral principles or practices;
2. Customs and usages of the profession;
3. Sound matters of policy not necessarily involving issues of morality in medical practice.

Clarification of Moral Principles, Customs, Usage

The last is necessary because sometimes the Judicial Commission might well base its decisions of unethicalness on conduct which fails to conform to custom and usages as reflected in MSMS policy. For example: Methods of charging for services if work is performed under contract with a hospital might give rise to disciplinary proceedings. Another example: The determination of whether a patient has the right to die is a question related to professional morals which has religious overtones which need the advice of the Medicine and Religious Committee and might require a philosopher's thinking as well. Yet both of these problems might fall within the responsibility of the Judicial Commission.

Advertising

Of late, considerable license has been taken by doctors who in an earlier day would have been found guilty of "advertising." This needs clarification in the light of modern communication media usage.

Disciplinary Measures

Disciplinary measures have never been spelled out on the state level and understood by the membership. This, too, could challenge the thinking of the Judicial Commission.

Joint Commission on Accreditation

The Joint Commission on Accreditation has served as a force to maintain standards. MSMS needs closer liaison with this Commission in order to understand its true function and properly interpret its decisions as being in the interest of the public and the profession. Due to the changing nature of the relationships of doctors with hospitals, it is a good guess that the Joint Commission's work will have a great deal to do with the practice of medicine in hospitals, with many aspects involving ethics and professional conduct.

Legal Counsel

Prior to the action establishing the Judicial Commission, the ethical rulings of the MSMS had been based upon the legal interpretations made by its General Counsel, who invariably indicated that his opinion was based solely upon the legalities involved and not upon the moral or ethical overtones.

Professionalism

Conclusion: This subject area which was carefully avoided by the MSMS for nearly twenty years is in need of systematic exploration. To do so will require not only legal but religious, philosophical, and medical research plus opinion sampling. This last line of defense of profes-

Continued on Page 74

...flexibility to meet new requirements

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sionalism can remain impregnable only if it is based on custom *plus reason,* with due recognition of the legalities involved.

Questions

Judicial Commission

A. Should there be a system providing for the continuous publishing of guidelines on ethics as issued by the AMA Judicial Council and the MSMS Judicial Commission?

Medicine and Religion
Moral Responsibilities

B. Should the Judicial Commission be asked to inaugurate (perhaps in cooperation with the Medicine and Religion Committee) an exhaustive study of the "nature and scope of new moral responsibilities of the medical profession" caused by rapidly advancing scientific and engineering knowledge, increasing population, e.g.

DNA Altering

1. Moral questions involved in altering the DNA pattern, such as changing of personality, physical attributes, etc.?

Population Control

2. Moral questions involved in population control?

Limited Supply

3. Moral questions involved in limited supply of lifesaving machinery and facilities?

Artificial Insemination

4. Moral questions involved in artificial insemination using frozen sperm?

Abortion

5. Moral questions involved in abortion?

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Human Relations - The Key

BY DON MARSHALL, M.D.
COUNCILOR, KALAMAZOO

It is comforting and reassuring to be informed once more that most patients like their doctor and their hospital, and are even more favorable to the doctor than the hospital. Such a report has just been published *based on a careful interview of 124 patients. They were accurately representative of the population of north Florida, hospitalized for a typical variety of medical illnesses.

Their confidentially expressed attitudes toward doctor and hospital were not correlated to age, sex, race, marital status, religion, occupation, education, social status, or size of home community.

WHY NEED WE BE concerned with the attitude toward us of our patients and of the public generally?

It is important that our patients understand what we are trying to do for them; it is important that the public understand the problems our profession and the health team and — yes — our patients too, face. If our profession is to be heard, if it is to be a leader in health care progress, it must have the respect and confidence of its audience, both patients and general public.

What are these problems?

There are many that doctor and patient face daily. The health team is shorthanded; there aren't enough doctors, nurses and others to meet demands and needs. Costs are rising precipitously. House calls are in some ways inefficient but may be necessary, and home care has its good points as well as economies. Specialization continues to increase, fragmenting the patient and his care.

EMERGENCY ROOMS ARE substituting for evening office hours. Patients wonder whether the best paid profession is earning its fees, so mediation cases increase. Results of care have improved so much that the inevitable failure leads to suits for malpractice or breach of contract.

These problems aren't new, but have been increasing in the last decade. Our attempts to solve them will be far easier if we have patients and public who are understanding and trusting of our efforts. Yes, the attitude of patients and public *is* of real importance to us.

There is today a widespread surge in planning, in an effort to make more efficient use of existing health facilities, to raise levels of health care and distribution. The medical profession could be a leader in the inevitable changes going on, if it will exert itself sufficiently. If we don't fill the vacuum, there are sociologists and bureaucrats eager to show the way. If we are to lead, the confidence of the public will be of inestimable help.

WHAT CHANGES ARE going on in the medical arena? Group practice is spreading, medical care is growing more urban and more hospital based. Specialization of the whole health team increases, with more and more being performed by technicians and aides, even by computers. Techniques and equipment grow more sophisticated and expensive.

Prevention of disease and maintenance of optimum health is being emphasized. There are increasing demands that the physician keep abreast, even that he be periodically re-examined and relicensed.

We must guard against self satisfaction because most of 124 patients in a Florida medical wing say they liked their doctor. We hope it is true in every state. We must, each of us, work to hold the respect and understanding of every patient, for in that human relationship lies our most important PR effort. Our public image **IS** important.

---

* Medical Inpatients' Attitudes Toward Physicians and Hospitalization: J. Florida M.A./pp 10561058, November 1967.

Photo professionally posed.

No injection after all!

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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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—Nearly 3 out of every 4 Negro students in Michigan attend predominantly Negro schools, those with 60 per cent or more Negro pupils.

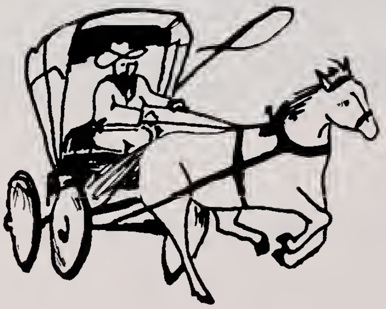
—Almost 3 out of every 5 white pupils attend schools where there are no Negro pupils.

—Some 3.6 per cent of public school buildings have student bodies of 95 or more per cent Negro pupils.

These are some of the highlights of Michigan's first public school racial census reported to the Michigan State Board of Education.

The first report was based on questionnaires returned by 3,374 principals and 63,469 classroom teachers of 1.8 million public school pupils.

The survey, State Board officials report, also found that 4 out of 10 public schools—40 per cent—have some outside non-neighborhood pupils in their classes, but that only 1.2 per cent have openly moved students around to achieve racial balance.



For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

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Doctors may be interested in reading a publication, Dialogue on Adolescence, *published by the United States Children's Bureau. The sketch with this feature article is from the publication. The booklet may be obtained by writing to the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402. Price 30 cents.*

Inner-City Youths Comment on Alcohol, Drugs, Sex Education

What recommendations would be made by inner-city youths about drugs, alcohol, LSD, and sex education?

Physicians are interested in the eight recommendations offered by the Michigan Youth Commission's "Open-Ended Youth Conference." Eighty inner-city boys and girls participated.

Drinking

During the recent conference, six discussion groups decided to discuss drugs, alcohol and LSD. Conference sponsors reported that "drinking received a great deal of attention with four specific recommendations." They were:

"1. Since most teen-agers do drink before they are 21, consideration should be given to lowering the age for drinking, or abolishing the law entirely. If this were done it might be that youth wouldn't feel the need to drink so much just to show that they are adults.

"2. Youth should receive more information about the effects of drinking.

"3. There should be more supervised entertainment.

"4. If the present laws on drinking are to be kept, they should be strictly enforced."

Narcotics

The Conference leaders also reported that "while the youth felt that there was a large amount of drug pushing around the schools, especially in certain neighborhoods, and that it was therefore a serious problem, they had few specific recommendations."

Following are the specific suggestions:

"1. Youth should be educated as to the use and effects of drugs and the danger of becoming an addict.

"2. The possibility of legalizing marijuana should be considered but this should be separated from other harmful drugs, like heroin, etc.

"3. Places where school youth get together should be checked to uncover dope pushers.

"4. Treatment should be offered to drug addicts.

Sex Education

"Sex education was considered by the inner-city youths as of great importance," the Conference sponsors observed. The boys and girls presented four recommendations:

"1. Sex education should be taught in schools, beginning in the sixth grade. In teaching this subject, there should be an explanation of how the biological, psychological and sociological factors are all inter-related.

"2. Birth control information should be taught some time in high school.

"3. There should be classes for parents to help them understand the best approaches to use in explaining the problems of sex to their children."

Comments Under Study

The conference recommendations on 15 different subjects have been presented to the Governor's office by the Michigan Youth Commission and representatives of the inner-city conference.

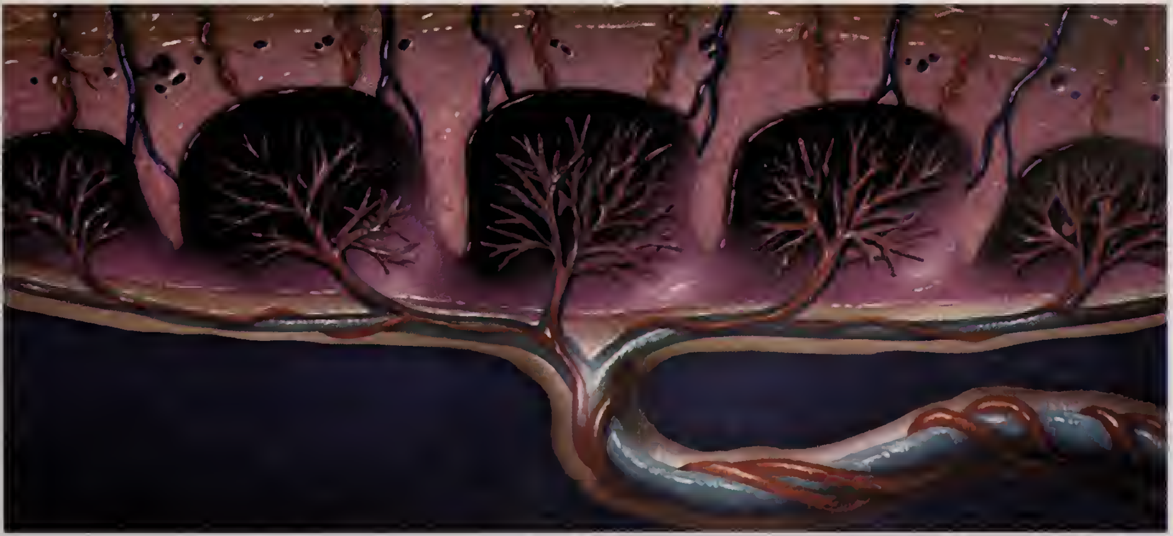
The recommendations now are under study by the MYC and its Youth Advisory Council for possible action projects.

The Youth Commission includes Irving Posner, M.D., Detroit; Eleanor Skufis, M.D., Adrian; Robert Heavenrich, M.D., Saginaw; and Herbert A. Auer of the MSMS executive staff.

winter 1968

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.



this issue: the cold in pregnancy...

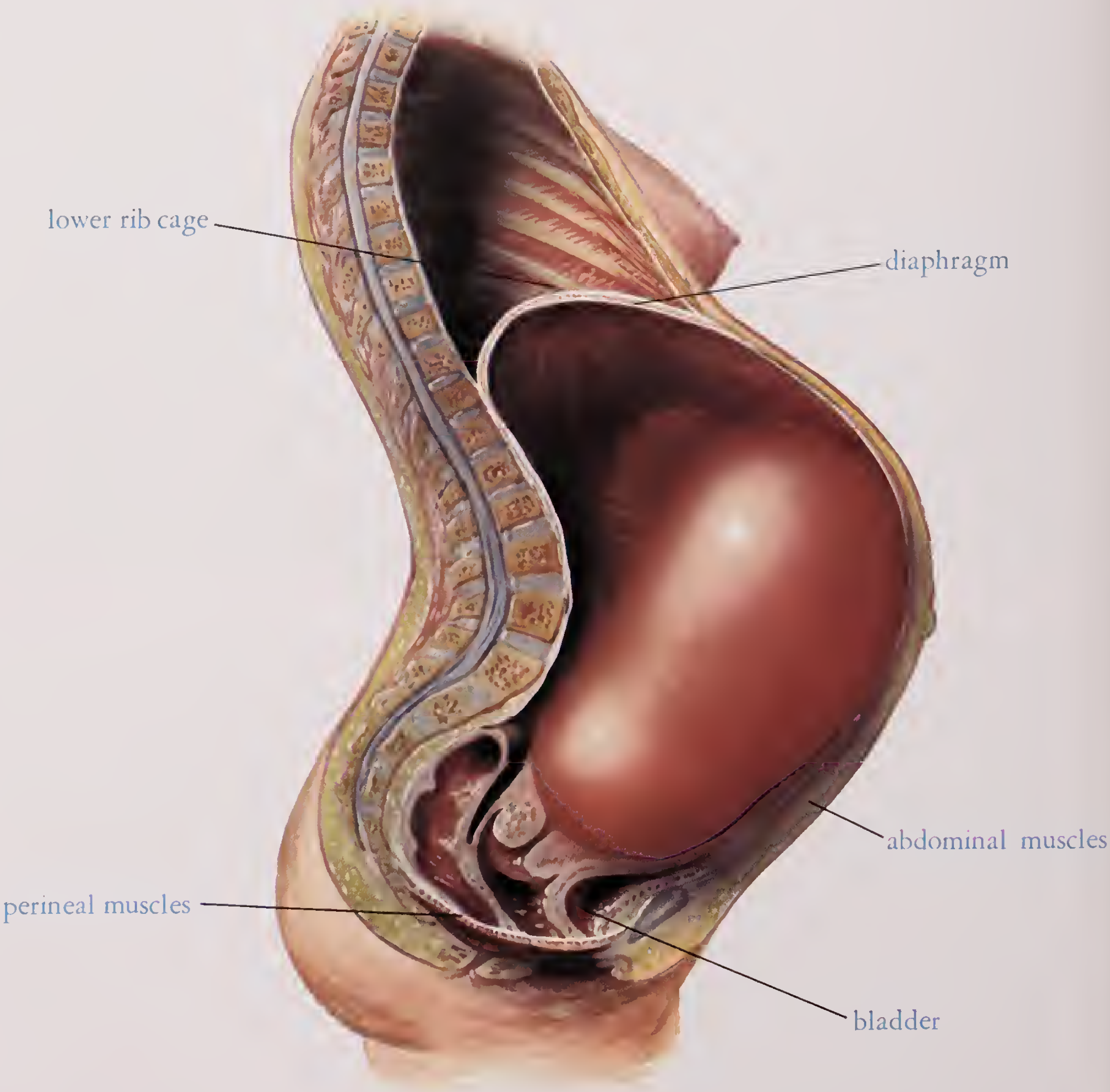
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...

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With its balanced formulation of an oral nasal decongestant and two antihistamines, Triaminic effected partial or complete relief in more than 82% of the 85 subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

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Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

the most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops The use of antibiotics in an uncomplicated cold i contraindicated and should be scrupulously avoided

In summary, a cold in pregnancy is more severe an longer lasting. The treatment of the symptoms wit local and systemic decongestants will make th patient more comfortable.

apparently the cold is so common in pregnancy tha it has received very little attention in the literatur References are almost non-existent and the fe which are available add little to the common knowledge, are out-dated, or are not helpful. Thus th usual bibliography is not appended.

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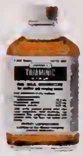
her concern, and about
half your phone calls.
Tell her to get
"The Orange Medicine"



Triaminic® syrup

Each teaspoonful (5 ml.) contains:

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MICHIGAN MEDICINE
DEADLINE FOR THE BREAKING NEWS WAS DECEMBER 26, 1967

Many Outstanding Authorities To Address 1968 Maternal, Perinatal Welfare Conference

"Practically all the speakers at our Seventh Annual Conference on Maternal and Perinatal Welfare this year are from outstate," announces Jack W. Thompson, M.D., of Flint, conference chairman.

"Physicians will especially be interested in the talk by John Gorman, M.D., Director of the Blood Bank at the Presbyterian Hospital in New York," Doctor Thompson said. "For the past few years he has been doing experimental work in the development and use of antibodies for the treatment of Hemolytic disease in newborn babies."

Doctor Gorman will speak at 10:30 a.m. on Wednesday, March 27, the second day of the conference. The MSMS Conference will open at 1:15 p.m. Tuesday, March 26, at the Pick-Durant Hotel in Flint, and close at noon on Wednesday.

The Clara Elizabeth Fund of Flint is cooperating again in the sponsorship of the conference.

Other talks of general interest to all physicians will be a discussion of "New Abortion Laws," by E. Stewart Taylor, M.D., from the department of Obstetrics-Gynecology at the University of Colorado Medical Center in Denver, and a discussion of "Infertility," by Herbert W. Horne, Jr., M.D., an internationally-known authority on infertility from Brookline, Massachusetts.

Since Colorado is one of the states which has liberalized its abortion laws, Doctor Taylor's comments will be valuable to Michigan physicians in light of the proposed liberalization here.

All MSMS members have received a complete program listing all the talks at the 1968 Michigan Conference on Maternal and Perinatal Welfare. There is no registration fee.

"Physicians who cannot come for the complete two days should feel free to drop in for any part of the program they have a special interest in," Doctor Thompson adds.

Heart, Cancer, Stroke Programs Moving in 49 Regions in Nation

"The imagination, knowledge, and energy to operate Heart, Cancer and Stroke Medical Programs will come from the local level."

So declared President Lyndon B. Johnson in a message to Congress with the first report on the Regional Medical Program. The President reported that more than 1,600 local health leaders — physicians, officials of medical centers, hospital administrators, teachers, and other health workers — are active as members of regional advisory groups.

In 49 regions (with all of Michigan as one region) alliances have been formed between medical schools, hospitals, and local doctors; 24 million dollars in Federal planning money has been awarded. At present the 49 regions cover 91 percent of the nation's population.

In five regions, cooperative medical programs are already operating with the help of 7.3 million dollars in Federal grants.

The Michigan Association for Regional Medical Programs (MARMP) received $1,285,155 on June 1, 1967 for its headquarters and for projects of the three medical schools and the state health department.

GEORGE CURRY, M.D., OF FLINT, DIES

George J. Curry, M.D., prominent Flint orthopedic surgeon, died November 29. He was 76.

Graduated from the University of Michigan Medical School in 1915, in 1920, Doctor Curry began his practice in Flint which he continued until his retirement to Florida last year.

He was affiliated with Hurley Hospital, Flint, where he was chairman of the committee on graduate training in surgery and director of the Cancer Registry.

Doctor Curry originated the first surgical training program in Flint and founded the section for trauma surgery at Hurley Hospital. In 1958 he was chosen to give the annual trauma lecture at the Clinical Congress of the American College of Surgeons. He received the "1960 Surgeons Award" of the National Safety Council for his studies on transporting the injured.

A past regent of the American College of Surgeons, he served on the board of governors of that organization in 1947 and was a past president of the Michigan chapter. He was a founding member and past president of the Flint Academy of Surgeons and a Life Member of the Michigan State Medical Society. Other professional memberships included the Central Surgical Association and the American Association for the Surgery of Trauma.

Doctor Curry was a member of the Flint Civil Service Commission for six years and was once medical director for the Flint Civil Defense Council.

TOWSLEY OUTLINES 1968 MUF PLANS

Plans for 1968 were outlined at the Michigan United Fund Campaign achievement luncheon at Kellogg Center December 4 by Harry A. Towsley, M.D., the MUF President.

The fall campaign topped all MUF drives.

RE-ELECTED SPEAKER FOR MED. ASSISTANTS

The American Association of Medical Assistants at its recent convention in Los Angeles reelected Betty Lou Willey, Port Huron, as speaker of its House of Delegates.

Betty is a past president of the Michigan State Medical Assistants Society.

SPEAKS ON SEX EDUCATION

"Sex Education for Teen-Agers" was the subject of the talk delivered by John R. G. Gosling, M.D., associate professor of obstetrics and gynecology at the University of Michigan, at the December meeting of the Bay, Arenac, Iosco Counties Medical Society.

PRE-MED STUDENTS HOSTED BY COUNTY MEDICAL SOCIETY

Members of the Gratiot-Isabella-Clare County Medical Society are pleased with the success of their recent dinner for pre-medical students of Alma College and Central Michigan University.

Andrew D. Hunt, Jr., M.D., Dean of the Michigan State University College of Human Medicine, addressed the group which included 29 junior and senior premedical students, several wives, MSMS Councilor Aaron C. Stander, M.D., Saginaw, and area physicians.

After the meeting, interested students adjourned to the home of one of the doctors for informal discussions.

An informal moment between Banquet Speaker Franklin V. Wade, M.D., (right) and Joseph L. Posch, M.D., Conference Chairman of the Trauma symposium.

WADE DESCRIBES VIETNAM WORK

"About 70% of our surgery was directly related to war injury," said Franklin V. Wade, M.D., speaking of his work in Vietnam in a luncheon speech during the second day of the December 6 and 7 Trauma Symposium in Detroit.

Doctor Wade worked with Vietnamese civilians for two months this past summer at one of the provincial hospitals in the Mekong Delta.

"We would begin each day by making the rounds in the hospital and looking at the casualties which had come in during the night," the Flint physician said. "In the afternoon I hoped to get at some elective cases, thyroid conditions and some huge tumors, but it was a rare day I could do so because the casualties just keep coming in. I generally did a major amputation each day. Reconstruction is practically impossible because of the sanitary conditions."

"One of the most vicious instruments is a foot mine which the VC plant in travelled places. Usually made out of an old beer can," he said, "It causes a great deal of injury among the people."

The Mekong Delta, according to Doctor Wade, has 6,000,000 people. The doctor-patient ratio for 1966 in that area is 1-32,000, and 1.4 hospital beds per 1000 people.

"As far as work with diseases go," Doctor Wade concluded, "You see practically everything which afflicts mankind: TB, parasites, typhoid, cholera, and all sorts of infections."

Babcock Predicts More Suits Charging Hospital Negligence

Hospitals and attending physicians can look forward to more frequent lawsuits alleging hospital negligence.

This prediction was made recently by Kenneth B. Babcock, M.D., a hospital consultant and former director of the Joint Commission on Accreditation of Hospitals.

Speaking at a recent Institute of Continuing Legal Education program on hospital liability law at The University of Michigan, Doctor Babcock said it is the responsibility of a hospital medical staff to "prevent incapable and unworthy practitioners from obtaining the privileges of the hospital."

"In my considered opinion," Doctor Babcock continued "the weakest single stone in the structure of hospital operation today is due to the failure of medical staffs to accept, and to discharge, these responsibilities."

Doctor Babcock, called for chiefs of staff to be appointed by hospital trustees.

Most chiefs of staff are elected by the staff with the concurrence of the board. But the chief does not, at present, represent the medical staff. "He derives his authority from the board and is accountable to the board for any actions of the medical staff," he said. "Few medical staffs realize this."

Doctor Babcock further predicted a "greater usage of informed consent." With such a consent form, physicians will be more free to treat their patients especially during emergencies and operations.

HONOR EDMORE DOCTOR

Myron G. Becker, M.D., celebrating his 50th year in practice, was honored for his service to the community of Edmore by a public reception on December 10. A committee, appointed by the Edmore Area Chamber of Commerce, made arrangements for the program.

National SAMA Convention Coming to Detroit in April

Plans are progressing on schedule for the Student American Medical Association national convention which will meet for the first time in its history in Detroit April 23-27.

The decision to hold the meeting in Detroit was basically "a tribute to Wayne State University during its Centennial year," according to Russell F. Staudacher, SAMA Executive Director.

At present about 70% of medical students throughout the U.S.A. are members of SAMA. Total registration for the convention is expected to reach 1500.

MSMS will assist the convention with a program grant of $500.

The national convention will begin on Tuesday, April 23, with a SAMA Council dinner in the evening. Awards banquet and presidential address will be on Thursday evening.

Grand Rapids M.D.s Tackle Medical Help To British Honduras

Three Grand Rapids physicians, at the invitation of George Price, premier of British Honduras, spent the week of December 10-17 in Belize, capital of the country, discussing the possibilities for increased medical assistance to British Honduras.

James Klomparens, M.D., Edward Jones, M.D. and Robert Burton, M.D. hope to establish a program under which Michigan physicians, on a rotating basis, will work on medical projects in British Honduras, Michigan's sister-country in the Partners of the Alliance.

"The country becomes independent in 1968," Doctor Burton said, "and many of the British doctors working on contract are expected to return to Great Britain. Perhaps we can work out a way to give some assistance."

Being inducted into the Michigan Health Council's Hall of Fame are E. Gifford Upjohn, M.D., board chairman of the Upjohn Company, Kalamazoo, left, and Emory W. Morris, M.D., center, president and managing director of the W. K. Kellogg Foundation. The awards were presented at a three-day institute by Harry A. Towsley, M.D., right, MHC president. Doctor Upjohn is the new president-elect of the Council.

MSMS Award Presented To Swan in Detroit

Seventy members of the Detroit Medical Society gathered with about 30 interns, residents and medical students from the Detroit area for an evening banquet, November 28, to honor Lionel F. Swan, M.D., for his work as president of the National Medical Association.

Doctor Swan received three awards at the banquet: A MSMS plaque presented by president-elect James J. Lightbody; a Detroit Medical Society plaque; and a parchment scroll from the City of Detroit, in light of the Common Council's proclamation of November 28 as Lionel F. Swan day. Doctor Swan had been unable to attend the 1967 Annual Session dinner dance to receive the MSMS National President's Award.

A featured speaker at the banquet was Waldo Cain, M.D., who will take over as president of the Detroit Medical Society in January. Also present was L. R. Swift, M.D., from Durham, North Carolina. Doctor Swift is chairman of the Talent Recruitment and Motivation Committee of the National Medical Association.

Pathologists Meet

Harry Oberman, M.D., Department of Pathology, University of Michigan, was discussant of a seminar on Tumors of the Breast at the meeting of the Michigan Society of Pathologists December 9, at the University of Michigan.

Problems of diagnosis, treatment and outcome of a wide variety of tumors of the breast were extensively discussed using fifteen different cases as examples. Doctor Oberman placed emphasis on careful differential diagnosis to offer the surgeon the best opportunity for proper treatment.

The Society will meet at Ford Hospital on February 10 for presentation of diagnostic procedures using enzymes.

UNIVERSITY HOSPITAL COSTS $30 MILLION EACH YEAR

It costs $30 million per year to run the 1,000-bed University Hospital at Ann Arbor, according to Ernest C. Laetz, the hospital's chief financial officer.

He said the entire sum, except for a psychiatric unit subsidy, is obtained from service fees charged to patients.

Cancer Foundation Hears Heustis

Albert E. Heustis, M.D., Executive Director of the Michigan Association for Regional Medical Programs, spoke at the Michigan Cancer Foundation's annual dinner meeting December 13, in Detroit.

Several awards were presented for outstanding service.

McCabe Outlines Shield's New Health Care Study

Michigan Blue Shield's national study on measurement and control of quality and efficiency of health care is being pursued vigorously "without preconceived goals or notions."

John C. McCabe, president of the Michigan plan, reported the study's progress in remarks prepared for delivery to the American Medical Association's recent national conference in Houston, Tex.

Mr. McCabe assured the AMA and its guests that Michigan is conducting "no culprit hunt" but is, rather, "criss-crossing the nation" to study existing care review mechanisms in other Blue Shield plans, in various government agencies, and in cooperation with studies under way at the University of Michigan and Yale, Brandeis, Johns Hopkins and Harvard.

The Michigan plan set aside $100,000 in June for the project, to be operated above and apart from standard quality and cost review. A team of medical and lay experts from the Blue Shield board of directors then established guidelines for the study. Staffing of the project began last month.

The result, Mr. McCabe emphasized, is intended to be a pattern which agencies throughout the United States can use to start health care and quality reviews, not a review itself.

Matters under examination are possible over and under use of facilities, cost and fee levels, regional socio-economic factors, profiles of treatment and a mass of matters impossible to explore until the new Blue Shield computer systems were established.

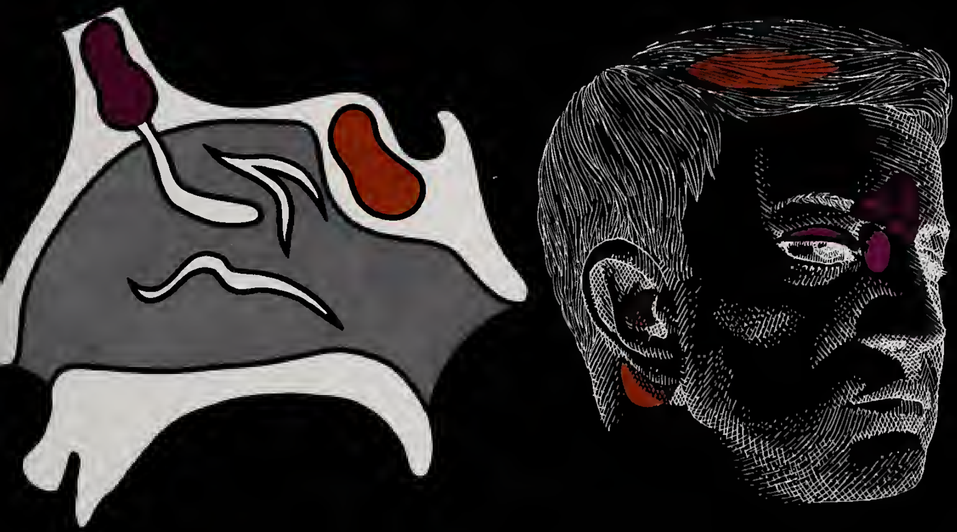
The review study "is not necessarily a dollar economy measure," Mr. McCabe said, because it "is possible we will find gaps in existing medical utilization which will be expensive to fill."

Even should some medical care abuses come to light, Mr. McCabe said, and thus disinter "some inevitable skeletons," the intent "is to give them quiet burial, not to rattle and brandish their bones."

Michigan Blue Shield is possibly best suited for the study, Mr. McCabe said, because of its responsibility in implementing the new automobile health care contracts nationally to Michigan standards and because of its role in regular business, which with Medicare and Medicaid involves service to about 65 per cent of the population. Michigan Blue Shield is building enormous reservoirs of information, Mr. McCabe said.

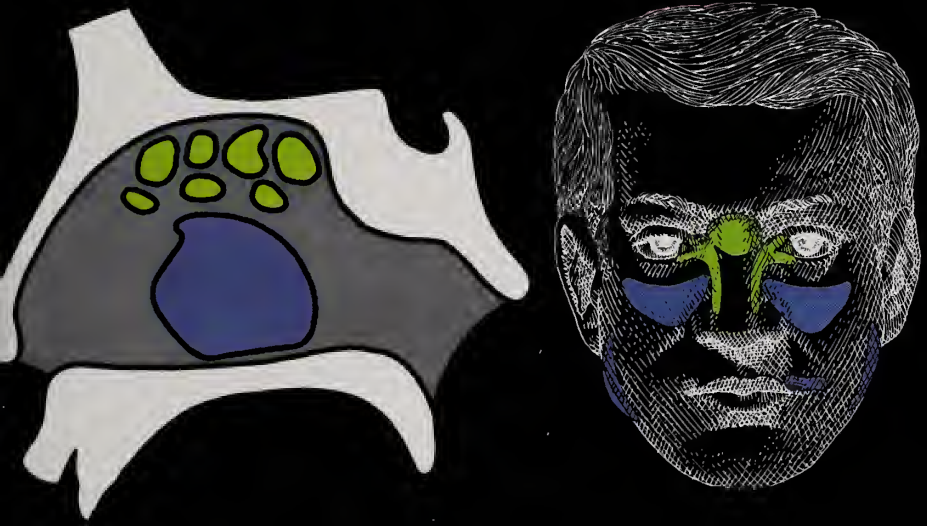
Blue Shield, Mr. McCabe said, "is the third party to the private physician-patient relationships in medicine, the only agency with the shared public and professional trust which a definitive study must have, the one with the records, data equipment, the know how needed for the job."

Sources of sinus headache

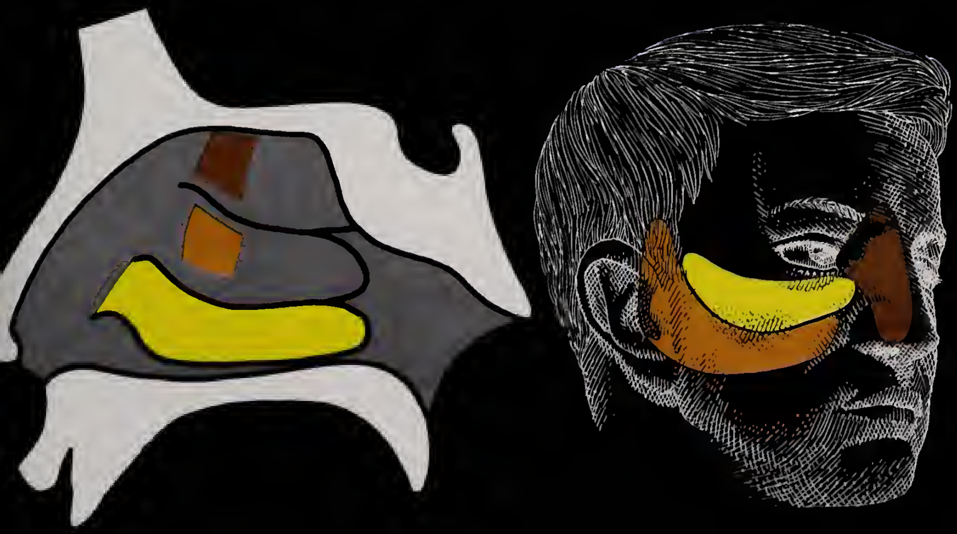


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

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COMING EVENTS

YALE RESEARCHER TO DELIVER 1968 BEAUMONT LECTURE

BY PETER HOHEISEL
OF THE MSMS STAFF

A Yale physiologist who has stopped a raging bull in midcharge, changed a loving monkey mother to a rejecting one, and turned a normally reserved young woman into a flirt will deliver the 47th annual Beaumont Lecture at Wayne Medical Society headquarters on April 1, 1968 at 8:00 PM.

Jose' M. Delgado, M.D., professor of physiology at Yale, will speak on the "Effect of Brain Stimulation by Radio Receptors."

The lecture is open, free of charge, to all physicians at 8:00 PM. Cocktails and dinner begin at 6:30. Dinner charge is $5.25.

One of his most widely known experiments has been to implant tiny electrodes in the brain of a female rhesus monkey and, through radio signal manipulation, change the monkey from a loving, protective mother to one who rejects her nursling. Besides changing emotional responses in monkeys, Doctor Delgado's experiments have also heightened already existing emotions. For example a charge in the brain of a boss monkey sent him into a rage against an unfriendly male in the colony, but his feelings for his friends remained the same. "The details of his aggression and directions of his hostility were set by previous experience," explains Doctor Delgado.

Treatment of epileptics and violent mental patients has sometimes involved similar techniques. Doctor Delgado cites the case of an 11-year-old epileptic boy with uncontrollable seizures and destructive behavior who was calmed down in preparation for brain surgery through cerebral electric stimulus. The charge, however, did not alter his facial expression, intellectual level, or basic personality.

Emphasizing that he is not concerned to manipulate normal human behavior, Doctor Delgado commented "I don't want people to think I'm against motherhood. He sees his research into the physical and chemical basis of emotion and thought as a help in developing new ways of treating the mentally ill.

MEDISCENE

Jan. 19-20—16th Annual Symposium on Blood, McGregor Memorial Conference Center, Detroit

Jan. 24—Seventh Annual Thyroid Workshop, Wayne County Medical Society Headquarters, Detroit

Jan. 24—The Council, MSMS Headquarters, East Lansing

March 6—The Council, MSMS Headquarters, East Lansing

March 13-14—Annual meeting of the Michigan Academy of General Practice, Sheraton-Cadillac Hotel, Detroit

March 26-27—Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 17—The Council, MSMS Headquarters, East Lansing

April 22-25—Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

Apr. 23-28—17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

May 1-8—Mental Health Week

May 8-10—Michigan Public Health Association, Inc., Annual Conference· Jack Tar Hotel, Lansing

May 10-11—Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 15—Annual Muscle Symposium Wayne County Medical Society, Detroit

May 18—Kresge Eye Institute Clinic Day, Detroit

May 18-19—Pediatric Clinic Days

June 5—The Council, MSMS Headquarters, East Lansing

July 18-20—The Council, Grand Hotel, Mackinac Island

Aug. 21—The Council, MSMS Headquarters, East Lansing

Nov. 11-15—American Public Health Association Annual Conference, Detroit

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.

In rare instances, transient cardi
arrhythmias have occurred in hy
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ceiving thyroid medication when
Tofrānil was added to the regime
Imipramine may block the pharm
cologic activity of guanethidine a
other related adrenergic neuron-
blocking agents.
The drug is not recommended at
present time in patients under 12
of age.
Adverse Reactions: Dryness of th
mouth, tachycardia, constipatior
turbances of accommodation, sw
ing, dizziness, weight gain, urina
frequency or retention, nausea a
vomiting, peripheral neuritis, mil
parkinson-like syndrome, tremor
rare cases of falling in elderly pa
tients, confusional states (with s
symptoms as hallucinations and
orientation), activation of psycho
schizophrenics and agitation (in

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a milestone in life
is marred
by depression...

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Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

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sure fall in hypertensive patients,
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lepression including agranulocy-
sensitization and skin rash
ding photosensitization, eosino-
, and mild withdrawal symptoms
idden discontinuation after pro-
ed treatment with high doses.
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ıce, decreased libido, and estro-
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Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
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THYROID WORKSHOP AT WSU SCHEDULED, JAN. 24

Wayne State University will hold its Seventh Annual Thyroid Workshop January 24 at the headquarters of the Wayne County Medical Society. Visiting professors for the day-long program will be John Stanbury, M.D., Professor of Experimental Medicine at the Massachusetts Institute of Technology, who will present a paper on "The Goiter Problem," and Harry H. Towsley, M.D., Chairman of Post Graduate Medicine at the University of Michigan Medical School who will discuss "Goiter in Michigan."

Alexander J. Walt, M.D., Chairman of General Surgery and Assistant Dean at the WSU School of Medicine, will introduce the program at 10:00 a.m. Registration will open at 9:00 a.m.

General chairman of the workshop is Myer Teitelbaum, M.D., Clinical Assistant Professor of Medicine at WSU. Program chairmen are Robert C. Douglass, M.D., WSU Clinical Assistant Professor of Medicine, and Joel I. Hamburger, M.D., WSU Clinical Assistant Professor of Medicine.

William S. Reveno, M.D., WSU Clinical Associate Professor of Medicine will discuss "Thyrocalcitonin." J. Joseph Pendergast, M.D., and J. Martin Miller, M.D., of the Henry Ford Hospital, will present a paper "Thyroid Reserve in Euthyroid Patients after Ablative Therapy for Diffuse Toxic Goiter."

Robert E. Mack, M.D., WSU Professor of Medicine, will discuss "Thyroid Function in the Newborn." Doctor Hamburger will speak on "The Contribution of Scanning to the Clinical Diagnosis of Thyroid Cancer."

Doctor Teitelbaum will give a case presentation entitled "Emergence of Peripheral Arterial Insufficiency During Treatment of Hypothyroidism." George Kadian, M.D., WSU Clinical Instructor in Medicine, will give a case presentation on "Thyroid Cancer 17 Years After X-Irradiation." A case presentation "Hydrocoele, A Manifestation of Myxedema" will be given by Doctor Douglass and Donald J. Jaffar, M.D., WSU Clinical Professor of Urology. A case presentation "Thyroid Function Studies in Untreated Pernicious Anemia" will be given by E. Marshall Goldberg, M.D., WSU Clinical Assistant Professor of Medicine.

MSMS TO BE REPRESENTED AT AMA CONGRESS

Recommended by the MSMS Council to attend the AMA Second National Congress on Socio-Economics of Health Care at Chicago, March 22-23, 1968, were: Robert J. Mason, M.D., Birmingham; Bradley M. Harris, M.D., Ypsilanti; and also Richard M. Campau, Herbert Mehler and Hugh W. Brenneman of the MSMS staff.

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ACTIVITIES, PROJECTS

FIRST PROGRESS REPORT ISSUED BY ECHO

Project ECHO (*Evidence for Community Health Organization*) has recently issued a first progress report in Michigan.

A project of the Michigan Center for Health Statistics, a division of the Michigan Department of Public Health, ECHO will develop a continuing appraisal of the health of the people of Michigan, and their social and physical environment, It will report these findings to the public and to local health programs.

A detailed explanation of the project will be carried in the February issue of *Michigan Medicine.* Authors are Morris Reizen, M.D., director of the Ingham County Health Department, and Robert Lewis, Ph.D., director of the Center for Health Statistics.

MICHIGAN DENTIST LEADS ADA AS PRESIDENT

F. Darl Ostrander, D.D.S., Ann Arbor, has begun his term as president of the American Dental Association. His wide experience in organized dentistry includes six years as speaker of the House of Delegates of the ADA. He has also been editor of the *Journal of the Michigan State Dental Association,* president of the MSDA, and for 18 years served on the ADA Council on Dental Therapeutics.

SEES PHYSICIANS LEADING CAR SAFETY EFFORTS

Charles E. Black, M.D., Lansing, addressed the fall seminar of the Michigan Adjusters Association in Frankenmuth on the "Autopsy Protocol" as it applies to the insurance adjustors and the insurance industry.

Doctor Black expressed the opinion that the physician is in position to lead in the anticrash-antiair-pollution automobile in the prevention of death and disease. "Man's closest friend in work and in play is the automobile, and is also man's greatest killer rivaling cancer and heart disease in the enormous death toll on our highways," he said.

Attorney Ralph Nader, who also spoke, stressed the need to improve automobile construction and to reduce air pollution by autos.

DETROIT CAREER PROGRAM TO USE "HORIZONS UNLIMITED"

Each year, during the first or second week in May, the Institute for Economic Education and the Detroit Public Schools sponsor a "Careers Unlimited Week" for high school juniors.

Various Detroit businesses and organizations arrange for groups of students to learn first-hand about career possibilities in the field of the student's choice.

Students who have indicated an interest in a health career will be hosted by hospitals around the city. This year, instead of furnishing a great number of pamphlets on particularized health careers, the Greater Detroit Area Hospital Council will provide the students with copies of *Horizons Unlimited,* the AMA booklet on health careers with a MSMS insert on where to get Michigan training in the health fields.

Physician's Cooperation Needed On Retardation Questionnaire

A special project in mental retardation is being undertaken by the Department of Health Development of the University of Michigan. This is a Public Health Service sponsored research to obtain the practicing physicians' opinion about the needs of mentally retarded children in his community.

Much pressure and considerable funds have been made available for a great expansion of facilities for the mentally retarded. Valuable time will be solicited for these programs from local physicians. Since they will be directly involved, it seemed important to those responsible for the special project to find out from physicians what they see as the needs in giving care to the mentally retarded.

The questionnaire is designed to be completed with the aid of an interviewer in approximately thirty minutes or less. The questions are designed to supply the following information; the number of patients with mental retardation seen and the frequency of these visits to the physician's office, present facilities available to the physician, brief generalizations about how each case is handled, and an opportunity to make recommendations for improvement of present programs.

All information will be treated confidentially. The information will be made available to the Michigan State Departments of Health and Mental Health and a scientific report will be prepared for publication in the near future.

This seems to be an extremely worthwhile project and one that is well worth the time of each physician who is interviewed. Your cooperation is urgently requested.

— George H. Lowrey, M.D.
Scientific Editor

HELPS PHYSICIANS FIND FOREIGN ASSIGNMENTS

AMDOC (abbreviation for AMerican DOCtor) is a non-profit corporation whose purpose is to aid people in the health sciences find foreign assignments. The organization is neither religiously oriented nor a government agency. AMDOC's roster of hospitals in foreign areas contains requests for general practitioners, specialists and allied personnel. The locations include South America, Central America, the Far East, Asia and Africa.

AMDOC receives applications from physicians, dentists and allied personnel for foreign assignments. They offer to serve as volunteers for periods from one month to three months or longer without compensation. They finance their own transportation. Their motivation may be a desire for broader experience or for giving of themselves, or both. It can be a challenging, rewarding and exhilarating experience. AMDOC encourages family participation as a means of education in basic international human understanding.

AMDOC assignments are acceptable for educational credit by the American Academy of General Practice.

Further information may be obtained in the office of the Executive Secretary, 27 East Canon Perdido Street, Santa Barbara, California 93101.

PHYSICIAN WINE TASTERS MEET IN DETROIT

To most people, wine appreciation is based on the practical norm of like or dislike.

A group of Detroit doctors, however, are involved in a unique educational program which takes an intellectual as well as a practical approach to the fruit of the grape.

Called the Physician's Wine Appreciation Society, the group at present numbers 25 members.

Organized last March, the society has held three meetings involving lectures, movies, and the existential method of education through actual wine tasting. Champagne was the center of attention in April, the summer meeting focused on California table wines, and the November meeting on Cognac. Wines for the tasting sessions are donated by the industry and its distributors.

Members of the society pay dues of $15 a year and receive subscriptions to several wine magazines, invitations to three or four gourmet dinners throughout the year, and, of course, the wine tasting evenings.

MSMS members may obtain further information from Charles J. Holt, Jr., M.D., Secretary to the Society, at 19515 Mack, Grosse Pte. Woods. Tel: TU 1-7277.

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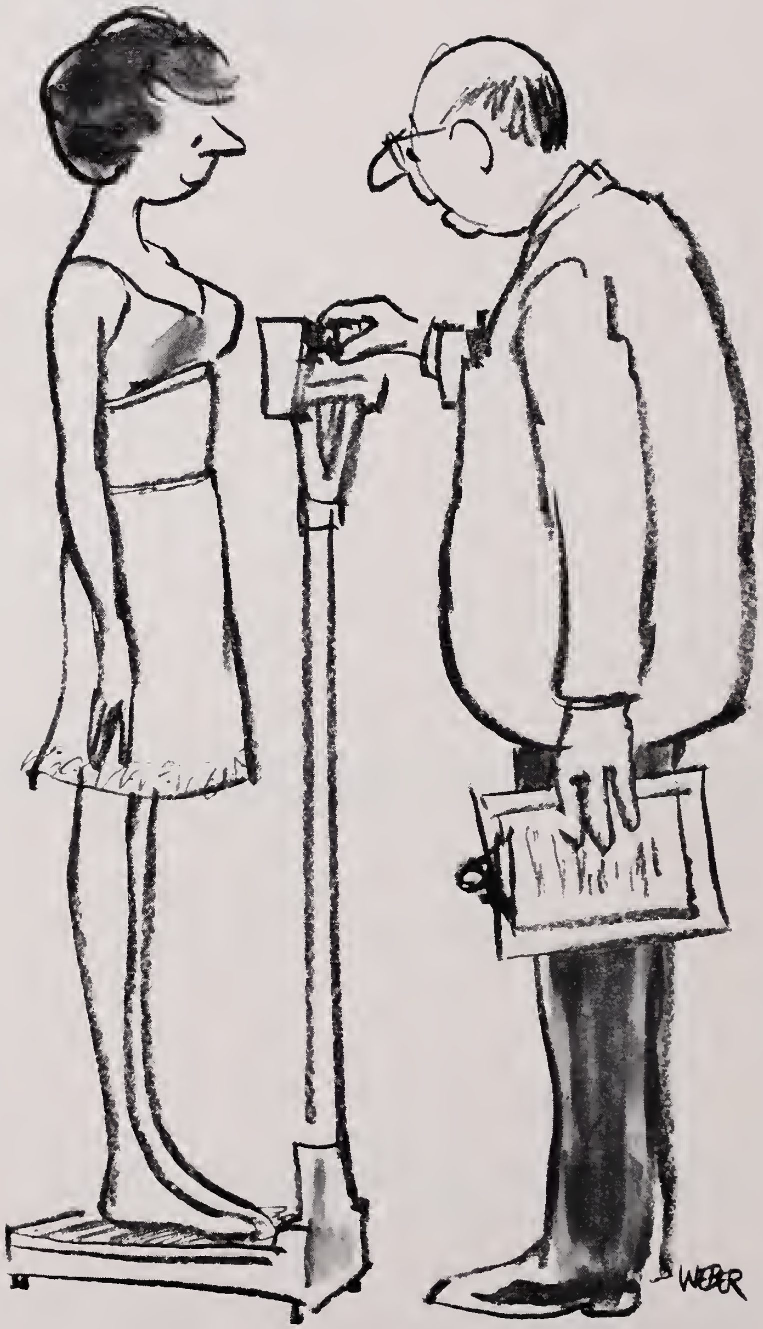

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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NEW SCHOOL NAMED TO HONOR FLINT M.D.

A Flint elementary school, which will open in the spring of 1969, will be named after T. Wendell Williams, M.D., a prominent negro physician from Flint who died in December 1966.

The school, to be built on Utah Avenue near Whaley Park in Flint, will have an enrollment of approximately 850.

Doctor Williams, a pediatrician, was the first negro to serve on the Flint Board of Education. Between the years 1963-1967 he served as both secretary and treasurer of the Board.

On announcing the decision to name the school after Doctor Williams, the Flint Board of Education said "It is especially appropriate that this school be named for a man who possessed an inherent faith in his fellow man's ability to bridge the gulf of racial, social, and economic differences — a man who worked constructively to impart better understanding and a broad range of positive cooperation among all people."

SHARE YOUR JOURNALS

FROM WORLD MEDICAL ASSOCIATION

Michigan doctors are being asked to send their medical journals — after they have read them — to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals.

We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, (*particularly specialty journals*), which you will mail direct to your overseas colleague.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will.

If you wish to participate in this program, send your name, address, and titles of journals you will contribute to DOCTOR-TO-DOCTOR PROGRAM, Ada Chree Reid, M.D., Director, % The World Medical Association, Inc., 10 Columbus Circle, New York, New York 10019.

WINS PEDIATRIC AWARD

Cameron Haight, M.D., chief of the thoracic surgery section in the University of Michigan Medical Center, has won the 1967 William E. Ladd Medal of the American Academy of Pediatrics. Given annually, the award honors him for his development of an operation to correct esophageal atresia and tracheo-esophageal fistula.

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CHICAGO MEDICAL SOCIETY

FEBRUARY 25-28, 1968

Palmer House, Chicago

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For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 South Michigan
Chicago, Illinois 60604

MICHIGAN STATE
MEDICAL SOCIETY

Every day, Michigan newspapers carry articles about medicine. Many of the articles are news releases processed by MSMS or are developed from tips and ideas relayed by the MSMS staff to editors and reporters. In the photo, several MSMS members look at some of the newspaper stories which were carried during the 1967 MSMS Annual Session, which is always a high point in the flow of news. MSMS placed a congratulatory advertisement in the current issue of Michigan Publisher, the official publication of the Michigan Press Association, commemorating the MPA on its Centennial year of service to Michigan readers.

WAYNE STATE INITIATES LEARN-BY-PHONE SYSTEM

By simply dialing a telephone, Wayne State University students can "retrieve" missed lectures, take tests and listen to assigned tapes through a dial access system being developed by the University's new Learning Resources Laboratory of the Systems, Distribution and Utilization Department (SDUD).

Dr. Thomas W. Roberts, Jr., director of SDUD, sees the dial access system as a significant breakthrough in the effort to reach more students in the face of increasing faculty shortages. He hopes this system will free instructional time to permit faculty members to relate more closely with their students.

"Within 10 years," predicts Dr. Roberts, "computers will perform switching operations and store learning materials so that students will actually talk with computers."

By using a cathode ray tube, a light pen, and a typewriter key board, students will ask the computer questions and answer those presented by the computer. The computer will tell if their answers are correct.

Students at home unable to reach the campus due to illness will "retrieve" lectures by telephone.

Togetherness....

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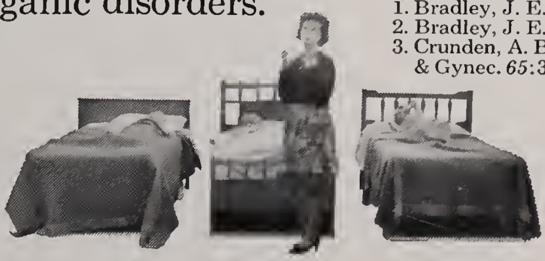

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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“FACTS ON QUACKS” AVAILABLE FROM AMA

Speakers at the quackery conferences which MSMS will be sponsoring throughout Michigan in 1968 undoubtedly will rely on “Facts on Quacks,” a new AMA publication, for much of their information.

The 32-page, illustrated booklet summarizes information about all kinds of health quackery in the United States. Written for the general public in question-and-answer form, the booklet covers quackery in arthritis and rheumatism, cancer, nutrition, weight reduction, over-the-counter drugs, alcoholic nostrums, health books and pamphlets, epilepsy, mental health and retardation, cosmetics, baldness, rejuvenation, and sex stimulants. The booklet also includes advice on what a person should do if he suspects health quackery activities in his community.

Various governmental and voluntary agencies in the health field such as the National Health Council, the Food and Drug Administration, the National Better Business Bureau, the Post Office Department, the Federal Trade Commission, the American Cancer Society Inc., and The Arthritis Foundation are giving full cooperation to the AMA in the publication of “Facts on Quacks.”

To get the booklet write: AMA Order Department. Single copies, 30¢; 50-99, 28¢; 100-499, 25¢; 500-999, 23¢; 1,000-over, 20¢.

U OF M SURGERY PROFESSOR NAMED TO SPECIAL BOARD OF MEDICINE

The National Academy of Science has set up a Special Board of Medicine and one of the 21 people chosen to serve on it is Charles G. Child, III, professor of surgery at the University of Michigan Medical School.

The purpose of the Board, outlined by Academy president Frederick Seitz, is to study means of more effectively applying rapidly expanding biomedical knowledge to critical human needs. Problems to be considered by the Board include such things as the ethical and legal implications of experiments involving humans and the role of medical schools in amelioration of urban and rural slums.

LAFAYETTE CLINIC PATIENTS SEEK WORK CONTRACTS

The industrial Work Program at Lafayette Clinic is seeking contracts and project work for patient workers who are paid for their services. Facilities of the program include a complete power wood shop, a computer laboratory, and a duplicating department. The workshop is also equipped to handle mailing jobs, including sorting, stuffing and packaging.

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Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

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Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

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You might also say that all interns aren't alike, either.

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Mrs. Clarence F. Miller presents Hemann K. Pinkus, M.D., with coveted DAR medal, while Hilda Hensel, M.D., also a recipient, looks on.

HUSBAND AND WIFE MDs HONORED BY DAR

Hermann K. Pinkus, M.D., and his wife, Hilda Hensel, M.D., Monroe dermatologists, recently became the first husband and wife to receive the Daughters of the American Revolution Americanism medals.

The Monroe Nancy DeGraff Toll Chapter presented the medals which are awarded by the national organization to adult naturalized citizens who have distinguished themselves as American citizens.

Doctor Pinkus and Doctor Hensel, both born in Germany, came to the United States as refugees in 1934 and 1935 and were naturalized in 1939 and 1940, establishing their practices in Monroe in 1940. They received their medical education in Germany and pursued advanced studies in the United States.

For the past 20 years, Doctor Pinkus has been a professor of dermatology at the Wayne State University Medical School and in recent years has headed the department. He has also participated in research at the Detroit Institute of Cancer Research since 1951.

KALAMAZOO RADIO SHOW CONTINUES POPULARITY

A five-minute, twice-a-week radio show, "Tell Me, Doctor," has been on station WKZO in Kalamazoo for the past 21 consecutive years.

Originally begun by MSMS, the program is now sponsored by First Federal. Each program consists of one question and an answer. Mental health, personal problems, effects of overtime work, epilepsy — these are some of the topics which have received a large amount of listener response, according to Irene Cowles, continuity writer for the station.

"Tell Me, Doctor" is on Tuesday and Thursday at 9:40 a.m.

Committee Seeks Information On Vietnamese Children

During the Korean war, many Michigan physicians adopted or sponsored the education of Korean children. The International Health Committee of MSMS is interested in finding out if any Michigan physicians are doing the same with Vietnamese children. If you are, please drop a note to MSMS, International Health Committee, 1010 Antietam, Detroit 48207.

FAMILY PLANNING DISCUSSED AT U OF M CONFERENCE

If you read newspapers you are more likely to practice family planning, according to Dudley Kirk, Ph.D., a Stanford demographer, citing a United Nations study which found newspaper circulation the most significant of 12 influences on national fertility figures.

Professor Kirk, speaking at the recent U of M sesquicentennial conference on "Fertility and Family Planning: A World View," pointed out that "information, health, and education items were found to be more closely correlated with fertility than economic, industrial, and urban development" in developing countries.

The population growth of 30 nations, including the U.S., is essentially under control. Population increases by 1 per cent or less a year in these nations.

The world population problem, according to Kirk, is related to whether or not the developing nations will follow the lead of Europe and America. Eight countries are in a transitional stage, approaching population control. Twenty-three countries in the developing regions have family planning programs.

"We are at a dynamic, perhaps decisive stage in the demographic transition," Kirk concluded. "It is a reasonable prediction that family planning will succeed and that, before the end of the century, most of the developing countries will be well along the transition to lower fertility and relief from the problems of rapid population growth."

The U-M conference also heard Richard Easterlin, economics professor and researcher at the Population Studies Center at the University of Pennsylvania, discuss the influences which bear upon American parents when it comes to family planning decisions.

Professor Easterlin stressed that income and attitudes were closely related in fertility decisions and called upon economists and sociologists to stop ignoring each other and develop a unified socio-economic framework for fertility studies.

HANDY BIBLIOGRAPHY ON HEALTH CAREERS:

Many MSMS members are explaining the need for more doctors and health-team workers in speeches to school assemblies, luncheon clubs, women's groups, church circles, lodges, unions, et al.

The AMA provides the following bibliography to help provide up-to-date health career information:

Utilization, Recruitment and Training of Health Manpower; Lenor S. Goerke, MD, M.S.P.H., American Journal of Public Health· 55:1511, October 1965.

Some Aims of Health Career Councils; Kevin P. Bunnell, Ed.D., Journal of School Health, 36:-416, November 1966.

Teenagers Learn About Health Careers at Statewide Conferences; Cherry Parker, R.N., Hospitals, JAHA, 38:74, October 16, 1964.

Hospitals and Schools Unite in Manpower Training Program; Robert M. Sigmond and Thomas E. Callahan, Hospitals, JAHA, 39:40, July 1, 1965.

Year-round Programs Set the Pace in Health Careers Promotion; Dorothy E. Johnson, Hospitals, JAHA, 40:57, January 16, 1966.

Horizons Unlimited; A Medical Careers Handbook, March, 1967 edition, American Medical Association, Program Services Department.

The Hospital People; (82-page, color Hospital Careers Booklet), 1967 edition, The Blue Cross Association (available through state and local Blue Cross Plans).

Put Yourself in This Picture of Health; 18½" x 22⅞" color Health Careers Poster, American Medical Association, Order Department. (single copies, $1.00; five or more, $0.50 each.)

The Opportunities and Rewards of Medicine Can Be Yours; pamphlet, 1966, American Medical Association, Program Services Department.

A List of More Than 30 Medical Careers Films Available for Loan; American Medical Association, Films Section.

Long-Playing Record Featuring 20 Health Careers Spots; (Designed for radio programming, but suited for use at health careers exhibits), American Medical Association, Program Services Department.

See John Run!

Washington State Heart Association has dropped the scare technique and is trying the light touch in propaganda against smoking. They talk about the pleasures of not smoking—better tasting food, unstained fingers, and whiter teeth. Non-smokers presumably can run faster to the bank with all the money they save by not smoking.

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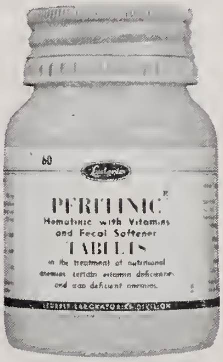
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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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MEDICAL PRACTICE TODAY DISCUSSED IN NEW AMA BOOK

To help new physicians and medical students grasp the complex dimensions of medical practice today and how it relates to the total community, the AMA has published a new 99-page handbook called *The Physician's Career.*

The Physician's Career results from suggestions made at recent AMA House of Delegates meetings. It was recommended that information on medical ethics, medical civics, and socio-economic aspects of medical practice would help students bridge the gap between medical school and actual practice.

The book, divided into 15 chapters, focuses upon the vast changes which have occurred since the time when the unaided physician was almost the only health resource in the community.

Group practice, the complex modern hospital, medical staff organization and responsibilities, community health services, governmental health programs, voluntary health insurance and prepayment plans — these are just some of the topics which are covered.

Copies can be obtained at 75¢ from: AMA Order Department, 535 N. Dearborn, Chicago, Ill.

ST. CLAIR COUNTY STUDIES TB SCREENING RESULTS

The results of the demonstration program that tested school personnel for tuberculosis in the Port Huron area this past fall are still being studied by the St. Clair County Health Department.

Robert E. Rowe, M.D., Director, St. Clair County Health Department, reports that, "So far we have found, out of a total of 708 school personnel tested, no active cases. However, 80 people, or 11% of the total, showed positive skin tests. Two people are still under study and are having further tests made."

The Southeastern Michigan Tuberculosis Detection Project moved into Port Huron under the sponsorship of the St. Clair County Health Department, to give T.B. tests to school personnel in the area.

The need for a demonstration program, explains Doctor Rowe, was the 1967 amendment to the Michigan Education Act requiring that school personnel get a yearly T.B. test.

"The new state law," Doctor Rowe recalled, "came about because of a case in Garden City in December 1965 when a teacher in a nursery school infected 18 children."

"While T.B. screening for school personnel is not specifically a health department responsibility, we thought we could help this year to fill the need created by the new law," he said. "We were lucky to get the assistance of the Southeastern T.B. Detection Project."

How could other communities organize to fulfill the requirements of the new law? "In smaller communities the doctors could organize a similar technical team to go from school to school or do the testing in their offices," Doctor Rowe advised. "In the larger areas, the Board of Education could contract with a T.B. testing team similar to the way we did it here."

"We don't plan to carry on the program next year," Doctor Rowe concluded, "because it is really a Board of Education responsibility."

MSU MED STUDENTS LEARN SENSITIVITY TO PATIENTS

"Simulated patients" and closed circuit television are helping beginning medical students at Michigan State University learn the "art" of medicine, along with the science.

The simulated patients are actors and actresses who have been coached to relate specific sets of symptoms and personality characteristics during interviews with medical students.

The primary aim is to enable medical students to become sensitive to the individual patient. This involves learning to relate to the patient, to bring out anxieties that may not be apparent, and to be at ease when discomforting subjects are brought up. Actual diagnosis of each case is only a secondary goal.

Each student conducted four interviews which were viewed live on closed circuit television by the instructor and other students and then played back to the interviewer and class. During the critique sessions, the instructor was able to stop the TV tape whenever he or the students wanted to discuss a particular point, such as possible rephrasing of a question.

One of the originators of the program, Hilliard Jason, M.D., Ed.D., director of the Office of Medical Education Research and Development said, "Simulation enables the student to focus on individual interviewing skills for practice and mastery. And, because the conditions are controlled and uniform, the instructor can make valid and helpful evaluations."

"An interesting point about using simulated patients," Doctor Jason noted, "is that the interviewer soon forgets the simulated patient is an actor or actress and becomes as involved as if the case were a real one." The cases, though different, all had something to do with pregnancy or the reproductive process, in order to make the current lectures and laboratory work of the students more meaningful.

Several Lansing physicians participated in the instruction and reported that they also benefited from the sessions.

"Yes, Doctor, the pain is gone."

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Each tablet contains: Codeine Phosphate gr. ½ (Warning – May be habit forming),
Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

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Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol

may potentiate hypotension. B
cause of the possibility of prog
sion of renal damage, periodic
determination of the BUN is in
cated. Discontinue if the BUN
or liver dysfunction is aggrava
Hepatic coma may be precipita
Electrolyte imbalance, sodium
or potassium depletion may oc
If potassium depletion should
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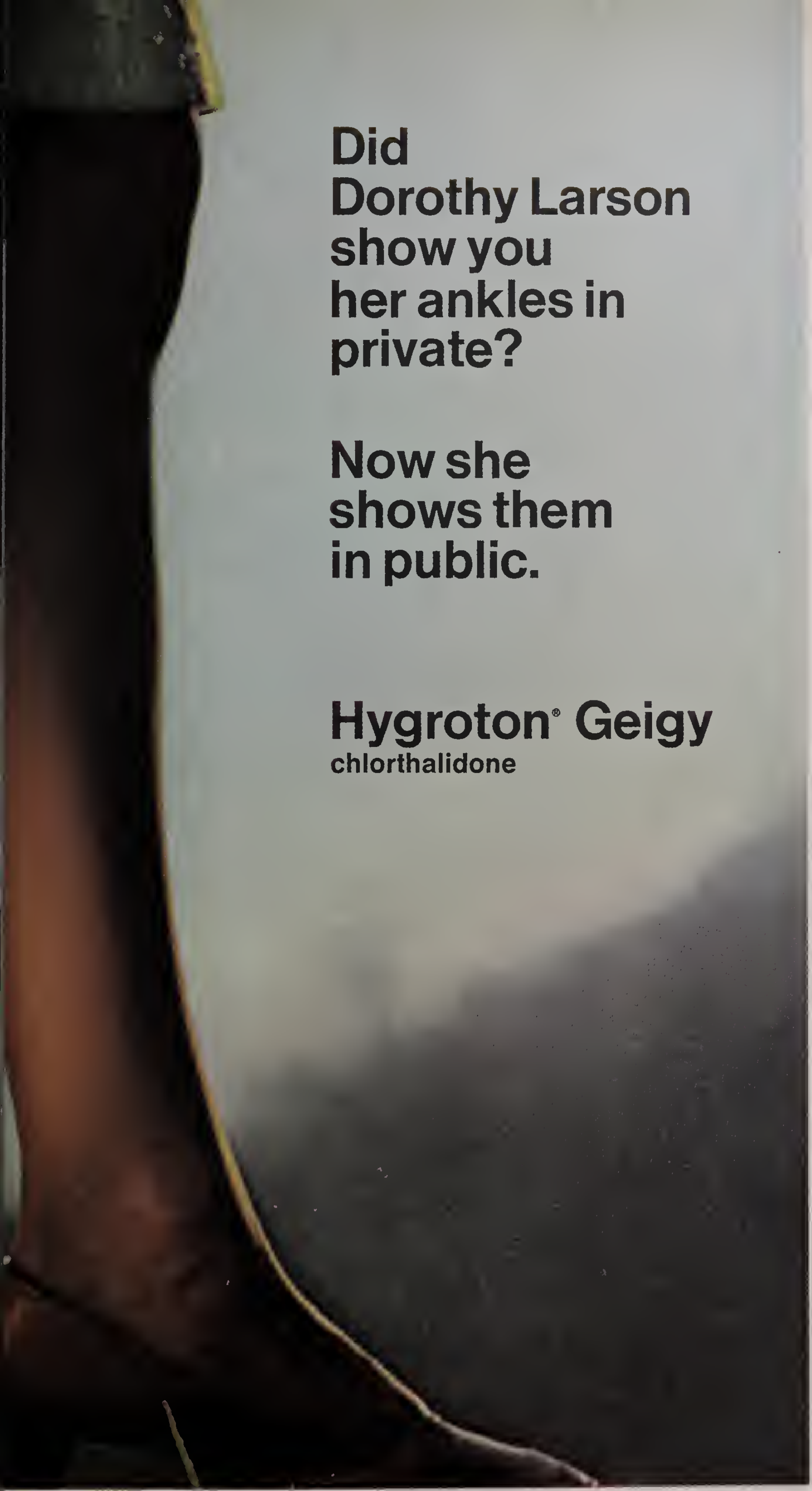

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Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton—to get rid of the edema.

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A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. A summary of the prescribing information is shown below.

nt does not have marked oli-
.
special care in cirrhosis or
e ischemic heart disease and
tients receiving corticoste-
, ACTH, or digitalis. Salt re-
ion is not recommended.
rse Reactions: Nausea, gastric
tion, vomiting, anorexia, con-
tion and cramping, dizziness,
ness, restlessness, hypergly-
a, hyperuricemia, headache,
le cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
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For full details, please see the complete prescribing information.

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Hygroton 50 mg. offers convenience for your patients who are halving the 100 mg. tablets or taking one every other day.

Geigy

Please see
preceding pages for
prescribing summary.

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Recalls Services of Detroit Doctor, Eberts, Beginning of 19th Century

(Editor's Note: — MSMS members, especially those in Detroit, will be interested in the early medical experiences of Herman Melchior Eberts, M.D., who was one of the first physicians in private practice in Detroit. Many of the adventures of Doctor Eberts, who arrived in Detroit in 1791, are described in Doctors Under Four Flags by Fannie Anderson and published in 1951 by The Wayne University Press. The following excerpts are published with permission.

"Herman Melchior Eberts, M.D., was one of the first medical practitioners to come to Detroit without some governmental or military connection. He was born in the city of Augsburg in 1753 of a family which claimed nobility. His medical education was acquired at the University of Vienna and the Allgemeine Krankenhaus, and he was supposed to have had graduate work at the University of Edinburgh.

"In 1774 he was commissioned an assistant surgeon in the *Landwehr,* but early in 1776 he accepted a commission as surgeon to the Hanau Hessian Regiment (Artillery), commanded by Colonel von Gall, which was in the pay of the British Government. The regiment sailed from Portsmouth on April 4, 1776, and arrived off Quebec on June 1. It spent the winter of 1776-77 in Montreal and fought at Ticonderoga. After serving fifteen months in the army, Eberts, at his own request, was granted an honorable discharge and safe-conduct at what is now Castleton, Vermont, on July 13, 1777. The discharge was written in French and described him as *"chirurgien et docteur."* On April 8, 1780, he married Marie Françoise Huc of Montreal. He was one of the first to conform with the Canadian Medical Act of 1788 requiring an examination and license to practice medicine in the Province of Quebec. The commissioners found that "he has been regularly bred to the profession of Surgery and we conceive he may be licensed to practice in Surgery and Pharmacy, or as an Apothecary." At this time he resided in Longueuil, District of Montreal.

"In 1791 he performed an autopsy on a young woman, contrary to the precepts of the Roman Catholic Church, and public opinion forced him to leave Montreal hurriedly.

"It was at this point in his career that he came to Detroit, but his family did not follow until 1795 or 1796. According to family records, he kept a drug store, sold wines and spirits, and dabbled in the fur trade, as well as following his profession. His home was near the corner of what is now Larned and Shelby streets.

"Eberts became coroner in 1796, one of the first appointments made by Winthrop Sargent for the newly organized County of Wayne. At the same time, George McDougall was appointed sheriff. When later in the year McDougall planned to leave on his usual winter trading expedition, he made an agreement with Eberts whereby the latter also took over the duties of the sheriff and paid McDougall a share of the fees accruing. This was done with the consent of the Judges, and McDougall went off to winter with the Indians. Eberts' commission as sheriff was revoked by the Governor of the Territory in 1798, in part probably as a result of Eberts' irascibility.

"In 1804 Marie Huc Eberts filed suit for divorce before the Circuit Court at Detroit, retaining Solomon Sibley as her attorney. It was asserted that her husband had "an ungovernable, cruel and unrelenting temper and disposition." Furthermore, he had not provided the necessities and convenience of life for her and their seven children, and on several occasions he had beaten her without cause. She asked for a divorce and alimony and was given a legal separation, whereupon she returned to Montreal. It was necessary to issue a warrant before Dr. Eberts appeared at the judge's chambers as ordered to sign the final papers on November 2, 1804.

"After the fire of 1805, in which his home was destroyed, he moved to the Canadian side of the river. During the War of 1812 he served as staff surgeon to General Henry Proctor's forces, and his four eldest sons also fought on the British side. For a second time he suffered the loss of his home by fire when the American troops invaded Canada in 1813. Among other valuables, a collection of botanical specimens, gathered in Michigan, was destroyed. After the war he resumed practice· cultivating a number of medicinal herbs in his own garden.

"He died on September 24, 1819, at the age of sixty-six and was buried by the Reverend Richard

Continued on Page 114

Pollock in the churchyard of St. John's Anglican Church at Sandwich.

Doctor Eberts was a gifted linguist, speaking German, French, English, and Latin, It is known that he kept meticulous records of his cases. Until a few years ago one of his case books was still in existence, but this too has disappeared. Fortunately, a description of it was published in a Detroit newspaper some forty years ago. It was a closely written manuscript containing about 350 pages, twelve inches long by eight inches wide, bound in parchment, and originally fastened with two clasps. Its first page was ornately written, possibly by a professional scrivener,

Livre de Compte
Pour
Medicament et Operations
De
Herman Melchior Eberts
Docteur au Medicine
Detroit
Premier Janvier
1796
Dat Galenus Opes.

"Patients came to Eberts from both sides of the river for some distance and among them were John Askin, Dr. William Brown, and Dr. William McDowell Scott. On occasion, Eberts probably contracted to provide medical care for a specified sum for a period of time. On May 15, 1811, Thomas Louis of Sandwich received a price of L4 for one year's medical care, and his family was treated at intervals through September 17, 1811. Apparently, cases which demanded more than the routine treatment of ordinary sickness were charged extra, and although the entry, "Received payment in full, L18," is undated, the confinement of Madame Louis on March 11, 1812, evidently required an additional L4.

"In some instances, however, patients refused to pay, and Eberts had to resort to legal pressure in order to collect. In December, 1796, the doctor brought suit in the Court of Common Pleas against a Joseph Thiebaut, Jr. for the non-payment of a bill for professional services. The court referred the matter to Drs. William Harffy and Charles Brown, surgeon to the American Corps of Artillerists and the Engineers at Detroit. Both physicians agreed that the bill should be reduced, and this decision was accepted by the court.

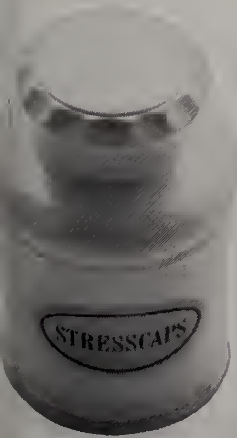
"Excerpts from Eberts' case book make it possible to piece together from several individual records the physician's methods of treatment. Bleeding was done frequently in the arm or foot, and patient medicines, such as Hamilton's Lozenges and Ching's Lozenges, as well as epsom salt and other drugs were prescribed.

"He also practiced obstetrics, which was rather unusual since most of the women in the Detroit area were predominantly of French ancestry and conservative in their ideas. Even in Philadelphia, the foremost city of the nation in culture and scientific advancement, many women still preferred to be attended by midwives. The entries in his case book on the confinement and post-natal care of Madame Thebedeau indicate the procedures followed by Eberts in this field of medicine.

July 10	Medicines	16*s*
	3 visits	8*s*
July 11	Bled arm, attendance	16*s*
July 12	Jalep, etc.	16*s*
July 14	Medicines repeated	16*s*
July 16	Epsom salts	6*s*
	A daughter born to Madame Thebedeau at nine o'clock in the morning; the child presented its right hand and right ear; the birth was miraculous and never seen before. After a half hour of labor I was able to bring the confinement to a happy conclusion	20*s*
July 18	Medicines	16*s*
July 26	Medicines repeated	16*s*
August 22	Salts	4*s*
August 26	Tincture of gentian	16*s*
September 4	Bols [bolus] purgative	4*s*
September 8	Jalap	2*s*
[No date]	Received payment in full	L26, 16*s*

"With the final disposition of the western boundaries and the establishment of a stable government more civilian doctors followed in Eberts' wake, but these men came from the states along the Atlantic seaboard, which had formerly been British colonies and were now incorporated in the United States. The physicians of this early period in American life have been frequently criti-

Continued on Page 118



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FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Optimil
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THE OPTIMUM-NUTRITION INFANT FORMULA

OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.[1-5]

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.[6] (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.[7-9]

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: ibid. 9. Nichols, M.: ibid.

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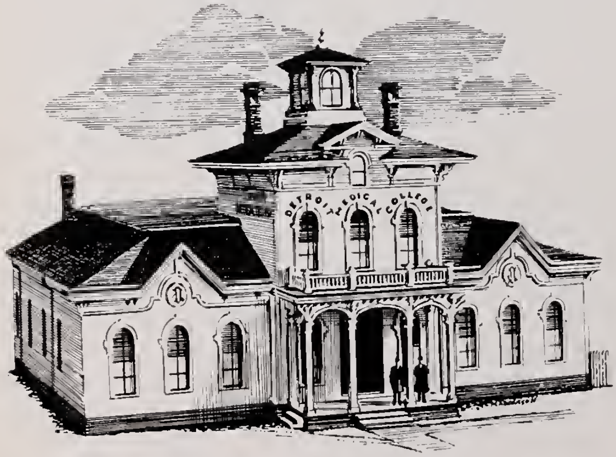
cized for their poor training and education and their lack of scientific interest. This indictment may be true, but a definite pattern, suited to a new country and a society untrammeled by Old World guild restrictions, was slowly emerging. Dr. John Morgan, one of the founders of the Pennsylvania Medical School of the College of Philadelphia, had advocated the separation of the three branches of medical science — medicine, surgery, and pharmacy — but this was not suited to the demands of frontier life.

"In the backwoods a physician was liable to be called for an emergency from dressing arrow wounds to treating malaria, and, as there were no corner drugstores, he usually carried his medicines with him."

MORE PHOTOS FROM WSU SCRAPBOOKS



AT LEFT — Wayne State University, in observing its Centennial, traces its history to the Detroit Medical College which was started in 1868 by a group of five doctors. In 1879 another college, the Michigan College of Medicine, opened in Detroit and the two merged to become the Detroit College of Medicine. In 1913 the name was changed to Detroit College of Medicine and Surgery and in 1919 it became an official part of the Detroit Board of Education in the Colleges of the City of Detroit. In 1933 the name was changed to Wayne University, and in 1956, Wayne became a State institution.

AT RIGHT — The WSU $4-million Medical Research Building, completed in 1964, was the first new medical structure to be erected in the Detroit Medical Center.

If hypothyroidism leaves your patient feeling like this...

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LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy

Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

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Farmers Shifting from Livestock To More Cash Grain Farming

Michigan physicians as consumers and many doctors as part time farmers will be interested in the current report from the Seventh Federal Reserve Bank District that "one of the more significant of many recent changes in Midwest farms has been the strong rise in grain production.

In the current issue of *Business Conditions,* the monthly publication of the Federal Reserve Bank of Chicago, the District officials report a "significant shift from production of livestock and livestock products to cash grain farming." The publication, in part, also declared:

"The proportion of cash receipts from crops marketed in the Seventh Federal Reserve Districts states increased from slightly less than 29 percent in 1959 to about 35 percent in 1964, based on the Census of Agriculture. Although there were fewer farms in 1964 than in 1959, the number of farms on which grain was a major source of income increased sharply both in number and as a proportion of the total of all farm types.

"THIS SHIFT IN TYPE of farm was especially evident in Illinois, Indiana and Iowa—the Corn Belt states of the District—but it also occurred in Michigan and Wisconsin. The proportion of cash grain farms (farms deriving 50 percent or more of their cash receipts from the sale of such grains as corn, small grains and soybeans) increased in Illinois from 38 percent of all farms in 1959 to 48 percent in 1964, from 20 percent to 28 percent in Indiana and from 18 percent to 24 percent in Iowa."

The federal agency reported that dairy farms dropped about 20 percent in Michigan, but because of the equally sharp decline in other types of farms there, the proportion of dairy farms remained nearly the same. In Wisconsin, the nation's leading dairy state, dairy farms declined about 14 percent in number and from about 66 percent of all farms in 1959 to 62 percent in 1964.

Almost all the decline, however, was confined to farms with small herds—the number of cows per acre actually increasing slightly in Michigan and Wisconsin.

FRUIT AND VEGETABLE farms, although accounting for only a small percentage of all farms, are important in some specialized areas, especially along Lake Michigan. These farms increased somewhat relative to other types in Michigan and Wisconsin but declined or showed little change in the Corn Belt states. Poultry farms, also of minor importance compared with all farms, declined in number in all District states, though they gained slightly relative to other farms in Illinois and Indiana.

The number of meat animal farms also dropped sharply during 1959-64—down one-fourth or more in each Corn Belt state. Somewhat smaller declines in Michigan and Wisconsin reflected the more limited farming alternatives in those states.

The Reserve Bank officials reported that "steer numbers increased in most counties of Michigan and Wisconsin, partly reflecting the shift from dairy to beef production on many small farms."

The *Business Conditions* publication explained that "a variety of forces contributed to the shift from the production of livestock to cash grain

Continued on Page 124

treat one . . . six people benefit

The brunt of senility falls on the family as much as the patient. But usually within one or two days, 'Thorazine' can control senile anxiety and fear . . . dispel the confusion shown by nighttime wandering and chattering . . . restore appetite and interest in personal grooming. Treat the senile patient with 'Thorazine'—the whole family can benefit.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.
Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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SK&F

in senile agitation . . . Thorazine® brand of chlorpromazine

WHAT DOES GALVANIC SKIN RESISTANCE DEMONSTRATE ABOUT THE EFFECT OF VALIUM (diazepam)?

Galvanic skin resistance...one measure of the Valium (diazepam) effect in reducing the somatic response to acute stress[1,2]

The subjective value of Valium (diazepam) has been proved by many clinical and empirical evaluations. Now, also objective criteria such as used in other areas of scientific research have demonstrated the effectiveness of Valium (diazepam) in reducing certain somatic responses to acute stress.

Devised as a research tool in psychosomatic medicine, this interesting method records respiratory excursions, galvanic skin resistance, cardiac activity and finger pulse volume as physical responses to stress. These autonomic nervous system responses to a standardized stressor—a film dealing with life-threatening incidents—are continuously monitored on the polygraph.

This gives a graphic representation of changes which the body may undergo in reacting to stress. The application of modern statistical analysis to these graphs provides a yardstick by which the calming effect of Valium (diazepam) can be measured quantitatively.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with a history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See *Precautions.*)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

References: 1. Selesnick, S. T., and Clemens, T. L.: From research film "Motion Picture Films in Psychosomatic Research," available from Roche Laboratories. 2. Clemens, T. L., and Selesnick, S. T.: *Dis. Nerv. System,* *28*:98, 1967.

ROCHE

VALIUM®
(diazepam) Roche®

useful for somatic symptoms
of psychic tension

farming. Greater possibilities for mechanization of grain farms than other farms have undoubtedly influenced the trend. Such field operations as planting, cultivation and harvesting have been increasingly mechanized, allowing crop farmers to do a given amount of work in less time. This, in turn, has often allowed them either to handle more acreage, intensify production or seek part-time employment off the farm—an opportunity not usually open to livestock producers.

"Also, the development and adoption of other technological innovations have made the highly productive land in the Midwest more suited for intensive cropping."

CROP PRODUCTION in Michigan, Wisconsin, Illinois, Ohio and Iowa, according to the Bank publication rose "about 14 percent during 1959-64. Corn production showed an even more dramatic rise—nearly 18 percent."

"Returns on the capital of cash grain producers in the Midwest also increased steadily throughout the period.

"Reflecting the general improvement in the incomes of grain producers, returns averaged more than for other major types of farms. This undoubtedly encouraged farmers to shift away from lower income enterprises wherever possible."

The publication, in looking toward the future, declared, "It is hard to say if Michigan and Midwest farmers will continue to reorganize their operations in the direction they did in the early 1960s. Returns to livestock feeders and dairymen have improved markedly in the last two years. If it continues, this improvement would, of course, tend to moderate the extent of a further shift toward more extensive cash grain farming. The improvement in returns on livestock may have been only temporary, however, reflecting the very high prices of livestock in 1965 and 1966."

The photos with this article are from the George C. Coats and Sons farm in Barry County and were furnished by the MSU School of Agriculture.

Associations Represent Every Interest Imaginable

Physicians are now paying their 1968 dues to the Michigan State Medical Society and it would be interesting to make a list of all the other associations that one supports through dues and personal participation.

There is no accurate estimate of how many local, state, national, and international associations there are, but the Chamber of Commerce of the United States acknowledged the vital importance of professional and trade associations in 1927 by creating the Association Service Department.

"LET'S GET TOGETHER!" long has been the byword of millions of Americans of all ages, from Boy Scouts to old duffers, who organize themselves into a wide variety of groups, ranging from the Pie Bakers Association . . . to the National Pickle Packers . . . to Girl Watchers Anonymous.

Let's get together! Federations, Organizations, Associations—and ultimately, the biggest American get-together of all—the Nation—all show that we are a people with a firmly rooted belief that things get done, and done better, when they're done in unison.

From the Asociation of American Poets to the Zoologists Society, the roster, from A to Z, swells to include thousands of associations that represent every interest imaginable.

There's the American Society of Mammalogists, a professional society of scientists, educators and conservationists. The American Mission for Opening Closed Churches is dedicated to re-opening same and helping them to become self-supporting.

If you think that an organization calling itself "The International Concatenated Order of Hoo Hoo" sounds like a convening of practitioners of magic, you might be surprised to learn that it's a fraternal order of men in the lumber industry—with a membership some 14,000 strong!

GIRL WATCHERS ANONYMOUS
?
ED MILLER

The popular adage, "You get out of it what you put into it," could very well apply to membership in professional or trade associations. The man who puts some of his time and money into the group of his choice not only helps support the organization and its work, but enriches himself as well.

There is even an American Society of Association Executives, founded in 1920, to keep associations, themselves, on their toes!

The national Chamber of Commerce and the American Society of Association Executives each year sponsor in-service institutes for association executives. (MSMS Staffer Herbert A. Auer is a member of the Board of Regents which plans these institutes at Michigan State University, Syracuse and other colleges.)

NEWSPAPER, MAGAZINE ARTICLES TELL ABOUT MSMS, AND DOCTORS

BY HERBERT A. AUER
MANAGING EDITOR

THE VIEWS OF Alfred B. Swanson, M.D., Grand Rapids orthopedic surgeon, on medical aid to Viet Nam were featured in a recent full-page article in the *Grand Rapids Press.*

Doctor Swanson urged escalation of "the second war, the war to win the friendsip of the people" through total commitment of medical aid. He was one of the twelve physicians who testified recently before the Refugee Subcommittee of the Senate Judiciary Committee that more money was mandatory. The USAID budget for medical assistance for Vietnam was, nevertheless, slashed by 20%. "The entire idea of vastly accelerating spending for the military aspects of the war, and then cutting back on the expenditures necessary to win over the people, is preposterous," he said.

Doctor Swanson, who has worked in Vietnam three times since 1962 and is now planning his fourth trip, described difficulties in getting even basic supplies and especially polio vaccine through official channels.

His conclusions and proposals were reported thoroughly by *Grand Rapids Press* writer William Schiffel.

* * *

THE HEADLINE SAID "Intensive Care Unit Paying Off" in the *Bay City Times* about the Mercy Hospital Intensive Care Unit which opened there in March 1967. John C. Mayne, M.D., Mercy chief of staff, declared, "The unit filled out a definite need in the community. I think on the whole the medical staff has been very gratified with the results." Doctor Martin Jaffe, head of the hospital's department of medicine, emphasized the usefulness of the unit for heart patients. Other kinds of crises handled were described. Comments by ICU personnel and former patients gave a good picture of the efficient care and cheerful atmosphere of the unit.

The by-line article was by Irene Beyst, *Bay City Times* reporter who participated in the 1967 MSMS medical Writers Conference.

* * *

FOUR COVERS FROM recent issues of *Michigan Medicine* were reproduced by the *PR Doctor* to illustrate the value of cover layouts emphasizing the subjects of leading stories. The covers shown featured sports medicine, a VD eradication campaign, treatment of alcoholism and the MSMS program on "Family Life Education."

The article praised the covers as varied and appealing. "Ever notice how many other journal covers remain static from year to year?" it asked. "Michigan's answer has hypoed eye appeal and reader interest."

* * *

THE RECENT ISSUE of *Auxilium,* the publication of the Woman's Auxiliary of the Michigan State Medical Society, carried a "farewell" article by Marge Karker. Mrs. Karker recently retired to Florida with her husband after serving as women's coordinator on the MSMS staff. In part, Marge wrote to the Auxiliary members,

> "You are an organization for just one reason—to assist your doctor-husbands.
>
> "It seems that there are two programs that should not be neglected:
>
> 1. "The recruitment of people into the health-related fields, by 1970 it is thought that more people will be employed in the health-related fields than in any other. Doctors need helpers—you can help them find them."
> 2. In the field of legislature. Doctors are too few in number to influence greatly in the legislative field. They must have the help of others. Doctor's wives can influence others to write their congressmen and legislators. The Auxiliary is trying hard to get information to doctors' wives relative to legislation."

Mrs. Karker closed her note by telling women to "don't discount or discard the idea that you have influence."

* * *

THE CURRENT ISSUE of the newsletter of the State Medical Journal Advertising Bureau, Chicago, tells all the other journals about a *Michigan Medicine* practice. The newsletter says *Michigan Medicine* has a good idea in running a regular boxed item which says, "The Advertising in *Michigan Medicine* keeps you informed and helps pay for publishing costs. When the local representative calls, tell him you saw his company's ad in your journal." The newsletter says, "there is no doubt about the power of a doctor's favorable comment." SMJAB and *Michigan Medicine* hope too that Michigan physicians "will write to companies whose ad strikes them as particularly good."

* * *

"The legislators who spoke at the recent MDPAC workshop are very devoted, concerned citizens, willing to look into each problem with open eyes before voting on it," declared the editor of a recent issue of the *LCMS News*. That's the attractive monthly bulletin of the Lenawee County Medical Society.

The report of the MDPAC Workshop stressed the importance of communications between the doctor and his legislator. The *LCMS News* observed that "legislators repeatedly stressed that they need the consultation and advice of physicians and others in making up their minds on the vital health issues." The writer reported that the workshop had given him "an appreciation for the life of a legislator, noting the fact that they (the speakers) are all of high caliber. . ."

* * *

Every week newspaper editorials pay tribute to individual doctors and their medical societies for meritorious service. Recently the *Battle Creek Enquirer and News* praised Richard J. Campbell, M.D. We quote, in part:

"People who work in many areas of community service must feel some dismay upon learning that Dr. Richard J. Campbell is about to retire and leave Battle Creek.

"During his years here, Dr. Campbell has given freely of his good counsel and leadership in many and diverse fields, both within and outside of his professional field of medicine.

"To mention only a few, he has been a moving force in the Family and Children's Service in alleviating human problems, in the social services planning of the Calhoun County Community Council, in the health care planning of the Battle Creek Area Hospital Funds, Inc., and its predecessor study committee, in stimulating youth through the Health Career Days he initiated, in youth service through the Boy Scouts of America.

"In more ways than we can count, this gentle and kindly man has contributed greatly to our community. Now that he is about to leave, we can only wish him well, knowing that in the years ahead he will continue to enrich the lives of those around him, wherever he lives. Such a man can't really retire."

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Suggestions on Selecting Medical Library Journals

(Editor's Note: The following article by Louis Krause, M.D., Chairman of the Maryland State Medical Society Library and History Committee, is reprinted from the Maryland State Medical Journal.*)*

With the information explosion librarians are often puzzled regarding selection of journals for their individual libraries. A good criteria for selection is the list of journals indexed in *Index Medicus,* published since 1879 by the National Library of Medicine.

How to maintain quality as well as currency in their selection of journals has been a major problem for the National Library. In response to many suggestions, the Library decided in 1964 to base their decisions on the opinions of special subject specialists acting as a panel.

As with other organizations, the limitations of personnel and funds have controlled the number of journals which can be indexed. Initially, during the formation of the panel, the 1000 journals selected from the *List of Journals indexed in Index Medicus,* through a previous 'user' survey as the highest quality journals, were indexed in depth. The other titles were given limited indexing; that is, not over four subject headings were to be assigned to entries.

ELECTRONIC BRAIN

"It's been wonderful at diagnosing but now it's coming up with diseases we haven't discovered yet!"

Following the recommendations of this panel, the chief of Bibliographic Services of the National Library prepared these criteria:

1. Sponsorship of the journal by a professional organization of recognized status in a given discipline or subject area.
2. Sponsorship by a national academy or national institute.
3. Existence of an active editorial board consisting of knowledgeable and critical referees with high professional standing.
4. Regular contributions to a journal by leaders in the subjects to which the journal addresses itself.
5. Strict adherence to an established format in presentation of methodology, tables, graphs, references and other data.
6. Publication policy that prohibits promotional, parochial, or secular approaches in the journal.

This information was excerpted from an article titled *Selection of Journals for Index Medicus* by Leonard Karel, PhD., National Library of Medicine in the *Bulletin of the Medical Library Association,* v.55, number 3, July 1967, p. 259-278. It is a comprehensive review of the subject and suggested reading for persons interested in one of the most specialized indexing projects in the country.

If librarians and physicians wonder why some of their pet publications do not appear on the *LJI* (List of Journals Indexed in *Index Medicus*) this article will shed some light on the methods of selection used.

LATEST AMA RECORDS, RE SPECIALTIES, ETC.

Latest *AMA records reveal the following figures:

300,163 — Total
287,163 — Total in active practice
187,100 — In solo, partnership, group and other
55,126 — In other practice
31,870 (Non-Federal)
21,950 — (Federal)
1,306 — Address Unknown
44,937 — Training Programs
40,709 — Non Federal
4,228 — Federal

GP-SPECIALTIES

70,223 — In general practice
65,591 — Medical Specialties
79,245 — Surgical Specialties
22,128 — Psychiatry and Neurology
48,670 — Other Specialties

---

*AMA, December 31, 1966

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GALENS HELP SICK CHILDREN

Thirty members of the Galens Society at the University of Michigan, took to the streets on December 1 and 2 to collect money to continue the children's workshop on the 13th floor of the University Hospital and to finance one in the C. S. Mott Children's Hospital now under construction.

"During the two days we collected $14,400," said Lee Britton, Galen's president. "We hope through the mail solicitation to get another $5,000 to $6,000."

"The reason we take up the collection at this time of year is because Christmas is the worst time for a child to be hospitalized," Mr. Britton continued. "The people of Ann Arbor are generous and proud of the project because they know every bit of the money they give goes directly to the cause to which they give it."

The donations help provide a workshop supervisor's salary, supplies, books, phonograph records, and special events such as carnivals and the annual Christmas party for each hospitalized child. Also three teachers are employed throughout the year to insure that the hospitalized children do not lose any school time.

Since its founding over half a century ago, the Galens honorary society has developed the Medical School's honor system, founded an annual lecture series, developed the system of upperclassmen counseling freshmen, and established loan funds for students. The Galens also sponsor special awards for outstanding students and teachers.

Parke-Davis Official Hits Drug Legislation

A Parke, Davis & Company executive has criticized proposed legislation that would force doctors to prescribe drugs by generic means for patients on Social Security.

"Our senior citizens deserve the right to obtain drugs of the highest quality, potency, and effectiveness," Joseph F. Sadusk, Jr., M.D., told members of the Rho Chi pharmaceutical honor society of Wayne State University's College of Pharmacy.

"It is my sincere belief that physicians should be permitted to prescribe for patients those products which from personal experience have proven to be safe and effective for their needs. The conscientious doctor simply cannot jeopardize the health of his patients by being indirectly forced or induced to prescribe products which may be inferior simply to save some relatively minor expense."

Doctor Sadusk, vice president for medical affairs at Parke-Davis, described as "disturbing" the proposed changes which would take away the doctor's prerogative of either himself designating the source of a drug for his patient or leaving this detail to the pharmacist.

AMERICAN LEGION SUPPORTS FAMILY LIFE EDUCATION

The American Legion and Auxiliary have addressed themselves to one of the goals of the MSMS Committee on Family Life Education, namely that courses stressing preparation for marriage and family life be taught in public schools.

At the Legion's national convention a resolution was adopted which in part, said: "The American Legion urges Posts to contact their local school authorities to ascertain if family life education courses to include such subjects as preparation for marriage and parenthood, as well as nutrition and health, are offered in the school curriculum." The resolution also stated "that in those communities where such family life education curriculum is not provided in the schools, the The American Legion seek the cooperation of the Parent Teachers Association, local medical societies, local public health departments, the clergy and mental health groups, to the end that such courses are instituted in the school system."

VISITOR IMPRESSED BY MSMS CEREMONY

The MSMS awards presentation at the Annual Dinner Dance impressed a visiting dignitary who has proposed that his state medical society "copy" the idea.

George F. Lull, M.D., executive administrator of the Illinois State Medical Society, was the guest who was impressed with the award ceremony. After the Annual Session, Doctor Lull wrote to MSMS Council Chairman Robert J. Mason, M.D., and said in part:

> "This is a brief note to tell you how much Mrs. Lull and I enjoyed our visit to the annual meeting of the Michigan State Medical Society.
>
> I think one of the high spots was the presentation of certificates to the presidents of national organizations and I am going to report this to the ISMS Board of Trustees to see if we can possibly copy the procedure."

The MSMS president at the Grand Rapids dinner presented nine awards to Michigan doctors who are serving as presidents of national medical organizations.

The award is given annually to MSMS members to recognize their leadership in national groups.

MANY SOCIO-ECON ASPECTS RAISED IN URBAN HEALTH REVIEW

BY EDWARD F. CRIPPEN, M.D., M.P.H.
DEPUTY COMMISSIONER
DETROIT DEPT. OF HEALTH

The ferment in the cities and recently the explosions are acts of people, and will not only be solved by construction but will answer the *needs* of the individuals, not his wants. Most of the money poured into cities is aimed at trying to salvage the central city, the downtown, by building malls, auditoriums, parks, parking ramps, the so-called civic centers, inhumane communities within the community, whose purpose is primarily to attract tourists to boost the economy. These are nice places for conventions and to work if you can afford the transportation or parking costs, but cold, lonely noisy places to live with the roar of trucks, screeching of sirens, the flashing and blinking lights.

To answer the *needs* of the *people* we must start by thinking about homes not houses, neighborhoods not super highways or great shopping centers, communities and not metropolitan areas.

TODAY'S MAN IS struggling hard to be an individual, evidenced by the hippies, the reactionaries, the civil disturbances, and the desire to belong to a minority group and preferably two, denoted by statements: "It is bad enough to be poor —to be poor and black is intolerable."

In light of the above, the urban health programs must be aimed at the individual and the family. Thus centers must be identified with and *in* the neighborhoods. They need not be large, may not be economical but should provide round-the-clock emergency service and accessible public health services where there are local practitioners plus medical care where there is none in that neighborhood.

THESE EMERGENCY SERVICES should be under the direction of a physician. In some cities general practitioners are now closing their offices and taking night duty at the hospitals, as total source of income; so could physicians be hired at the health clinics to direct and repair lacerations, puncture wounds, treat toothache, give tetanus and rabies shots, tend a midnight fever, detoxify alcoholics, evaluate mental crisis and perhaps give some therapy if not drugs, pump out swallowed poison, diagnose and treat venereal disease, perform multiple screening exams including pap exams, examine and make proper referrals of surgery or medical patients. He should be supported by a clinical and public health nursing staff that would relate to the family in the home and in the *neighborhood* school and nursing homes.

This neighborhood should have its school, its home of health, its park or recreational area. Thus each person in the neighborhood can relate to where he lives as his community. There will be less desire to destroy it. The advantages of a small town are thus built-in.

THE URBAN HEALTH departments must and need to take a part in housing inspection. Noise levels as well as inadequate lighting must be controlled. Schools must have and abide by the same health recommendations as the hospital; that is, adequate lighting, space, restrooms and health protection. Urban hospitals need also to be brought up to basic standards for health.

It is not unrealistic to have such a center for every neighborhood of 5,000 people. This would mean 500 for all of Detroit; as compared to less than a handful at present.

Real effort must be made to promote cleanup and fly and rat control in each area to be carried out by the neighborhood. Cities themselves must control the air pollution where there are the major sources, and the water pollution. Urban areas are where cities find pollution most difficult to abate.

Sewer, air, solid waste, water control must be under the metropolitan authority because they are better controlled and cheaper. With the abatement of water pollution, more rivers and lakes will provide more safe recreational areas.

The cost of follow-up of immunization, tuberculosis and venereal disease is much more expensive because of the rapid relocation of some families for various reasons—mostly economic, lack of neighbor association, no orientation to family or culture, and a jungle of dilapidated houses.

SCHOOL FUNDS ARE more limited because of lowering tax base and thus few school systems support the school health program financially. In city-county areas of public health, population increase allotments are frequently made on the last census which in some cases means no money is appropriated for thousands of recently arrived disease-ridden people in the city.

Transportation is a real problem in giving and providing medical care. Buses are expensive and may not go in the right direction. Cars are not cheap. Nursing homes also should be in the neighborhood, the "Village in the City."

Lastly, but by no means least, public health laws need to control occupancy and even population of areas.

Many of the health problems in the city could be solved by (like Puerto Rico did) shipping one-fourth of us out of the city to another smaller one, but that would only create more problems for the Federal government elsewhere. Thus the storm over the cities goes on. Can we build a dam that will protect us from the threatened flood? We have to!

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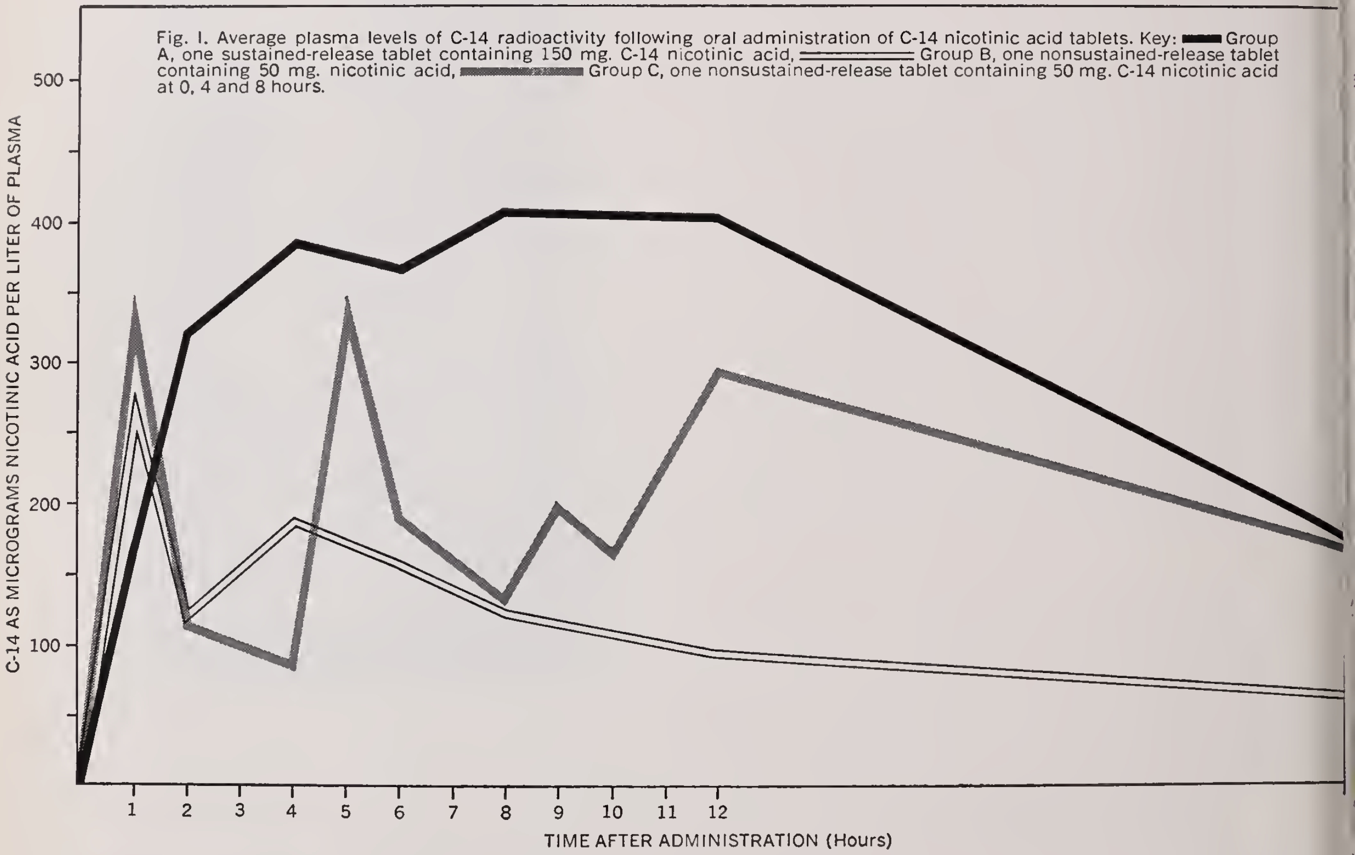

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

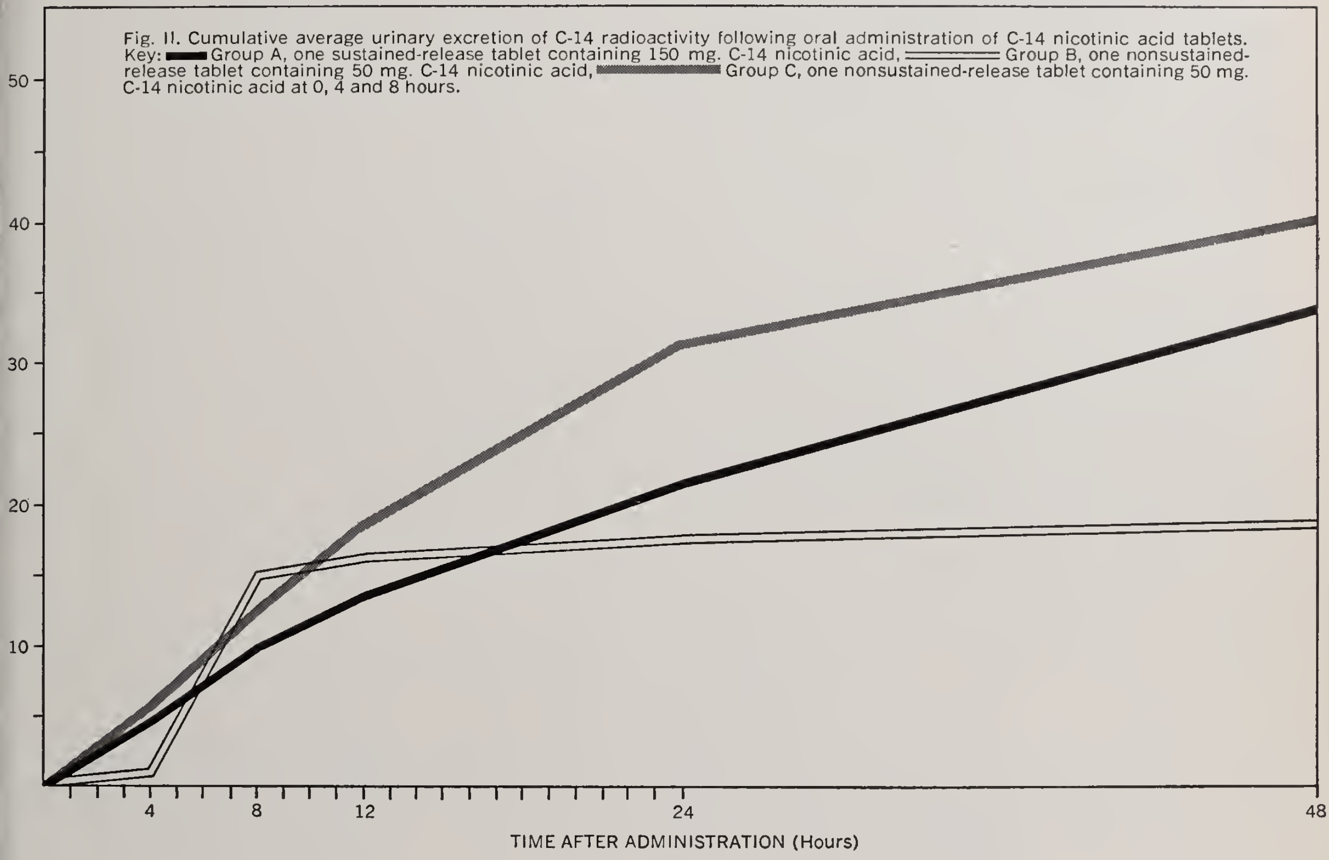

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ss confused and moody. Personal care, memory, notional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Help Offered Physician in Reporting His Earnings for Social Security

BY: ROGER W. SEAMON,
DISTRICT MANAGER
U.S. DEPARTMENT OF HEALTH,
EDUCATION AND WELFARE
SOCIAL SECURITY
ADMINISTRATION
DISTRICT OFFICE
216 TOWNSEND STREET
LANSING, MICHIGAN 48914

Sometime between now and April 15 each of us will go through the annual ritual of "filing the income tax return." This year, for only the second time, doctors of medicine will be paying Social Security self employment tax on the net profit from their private practice of medicine. Since this is still a new matter for most physicians, there are several unanswered questions which I would like to discuss.

You report your earnings for Social Security purposes as part of your income tax return, just as other self-employed people do. To do this you use a Schedule C in addition to the usual Form 1040. (The Schedule C has a subsection, called Schedule SE, which is very important to the matter of reporting net profit for Social Security purposes. We will discuss this form later.)

The Schedule C should be used to list only income and expenses directly related to business activities covered by the Social Security Act. Therefore you should report on your Schedule C only income and expenses directly related to your private practice of medicine. In other words, it is a profit and loss statement for your business activities as a physician. Income and expenses not directly related to your practice of medicine are *not* reported on this Schedule C but are reported on other forms, e.g. Form 1040, as appropriate.

The Schedule SE is a resume for your net profit covered by Social Security. The net profit, from your private practice, up to $6600 is reported on this form, along with your name and address, your Social Security number and the amount of the self employment (Social Security) tax due on the net profit. For 1967 earnings the self employment tax rate is 6.4% or $422.40 on $6600 of earnings. Be sure that your name and Social Security number are shown correctly on the Schedule SE. (Your Social Security number and tax payer number are the same). If you have had other earnings covered by Social Security, i.e. from employment for a corporation etc., the amount of net profit subject to the self employment tax is reduced by this amount of other earnings.

The Schedule C and SE are filed with the Internal Revenue Service as part of your personal income tax return. The self employment tax is included with the income tax paid with the return. IRS reports your self employment earnings to the Social Security Administration and credits your self employment tax to the Social Security Trust Funds. No separate report nor payment need be made to the Social Security Administration.

Each year's report is recorded to your individual Social Security account. These accumulated annual earnings will determine what your benefit will be when you come to apply for benefits sometime in the future.

In the meantime we recommend that you periodically check on the amount of earnings recorded to your account in our files. We have a post card request form that you can use about every 4 years. This card is sent to the Social Security record center in Baltimore which will send you a report of the earnings recorded to your account. The report will show the total earnings accumulated in your account. In addition it will give the amount credited for each of the past 3 years. If this information is incorrect, your Social Security office will assist you in correcting our records. In this way you can insure that your earnings are properly recorded in your Social Security account.

EXHIBIT SEEKS EAR TRUMPETS

Have you found any ear trumpets lately? An ancient hearing aid, perhaps? Eh? Yes, you heard (read) correctly.

Any early hearing devices, articles used to relieve hearing problems, or early testing equipment such as tuning forks, whistles, etc., are wanted by the Kresge Hearing Research Institute at the University of Michigan.

Merle Lawrence, Director of the Institute, is establishing an historical exhibit of such devices. Persons wishing to contribute items are requested to contact him at the Institute in the University of Michigan Medical Center, 1301 Ann Street, Ann Arbor.

LEADS LENAWEE STUDY

Richard Dustin, M.D., President of the Lenawee County Medical Society, has been named chairman of a committee of doctors and laymen newly-organized to investigate the possibility of creating a county mental health board.

MSMS PR Committee Suggests Use of AMA Health Guide

Today's Health Guide, the American Medical Association's fast-selling manual of health information, has gone into its third printing, and is now available in book stores.

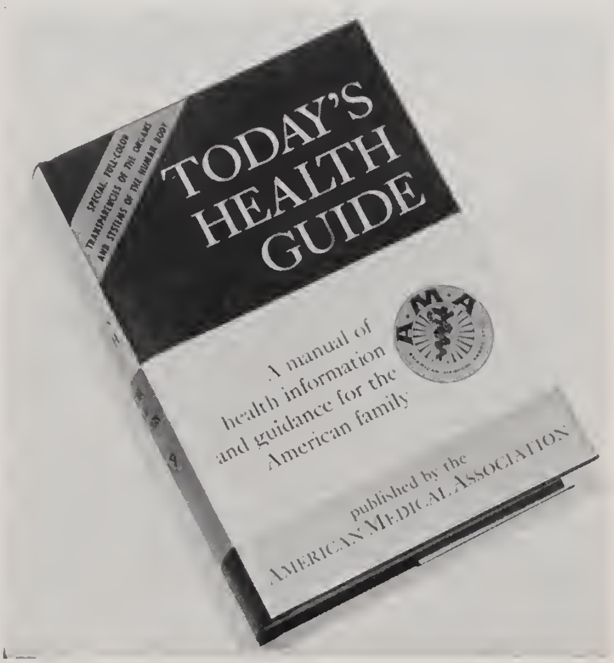
The MSMS Public Relations Committee urges component societies to distribute copies to libraries, newspapers, etc.

More than 250,000 copies have been sold.

Today's Health Guide has 90 chapters, each dealing with an important aspect of health in the family. It is illustrated by hundreds of easy-to-understand drawings, including "trans-vision," or full color "see-through" drawings, of the organs and systems of the human body.

The guide is the product of many doctors and allied scientists. More than 200 people had a role in its preparation—practicing physicians and specialists, dentists, veterinarians, clergymen, chemists, physicists, nurses, educators, engineers, safety experts, writers, reviewers, and members of the AMA staff.

Today's Health Guide is available through your bookseller or by mail order from the American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610, for $5.95. Check or money order should accompany each order.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MAILBAG

I just want to tell you how much PMA and its members appreciate the assistance of *Michigan Medicine* in publicizing our new advertising project in the *Reader's Digest.* We have been informed by our agency that you requested a plate of our "Dear Doctor" ad, to help enable your members to order packets of reprints of our *Digest* booklet to distribute to their patients.

A most gratifying number of journals have made use of the plate and I am glad to say that many hundreds of physicians have responded.

Whether the approach we have taken will be successful in informing the general public of the achievements and problems of the pharmaceutical industry remains to be seen, of course. Meanwhile, the early reaction, including your own expression of interest, has been very encouraging.

Sincerely yours,
C. Joseph Stetler, President
Pharmaceutical Manufacturers Association

Dear Doctor Lowery:

I am sure you expected some comments on your discussion of the "Dangers of Adenotonsillectomy" published in Viewpoints in the last issue. I am glad to contribute my thoughts on this important point.

There is no question but what the philosophy of the conscientious physician involved in making the decision concerning adenotonsillectomy has changed in the recent past. The T&A was often considered necessary in the growing up process. We all know that is not correct. However, to state that the "only valid criteria for adenotonsillectomy are documented recurrent ear infections with increasing hearing loss or peritonsillar abscess" seems to me to be understanding the situation a bit. There must be something to be said for the case in which multiple bouts of acute severe tonsillitis are occurring in rapid succession requiring loss of school or work time, the use of expensive medications, but most important the exposure to possible serious complications. Your criteria also does not include the rare child who has problems swallowing food because of the mechanical obstruction due to "kissing" tonsils and what can one suggest for the child who has constant mouth breathing with its side effects (other than T&A). No knowledgeable physician recommends T&A to reduce the number of undifferentiated upper respiratory infections nor to stimulate the appetite of the anorexic child or the one who is not thriving.

101 deaths out of 1,200,000 T&A's in 1964, of course, are regrettable; however, I suspect that deaths from complications of disease related to these structures and reactions to medication used in their treatment in an equal number of individuals would be more than 101.

I am in thorough agreement that unnecessary T&A's are to be condemned but I am also strong to encourage the very carefully performed adenotonsillectomy in the individual who, with little doubt, will benefit from the procedure. Let's concentrate on urging closer supervision of the postoperative period and the encouragement of absolute perfection in the anesthesia, hemostatis, recovery room supervision, and convalescent period.

Sincerely,
Dean C. Elliott, M.D.
Department of Otolaryngology
Burns Clinic Medical Center
Petoskey

The MD-PAC political workshop was quite an interesting and valuable experience. I would like to express my thanks for the invitation to attend this workshop for I feel that exposure to organized medicine is both a valuable and necessary part of any medical students education.

Thank you.

Sincerely,
James A. Ruggles
(MSU Medical Student)

I thank you again for inviting me to participate in the proceedings of the Michigan State Medical society. As an educator, I was delighted to be included in the discussion of the vital area of family life and sex education.

Your society has made positive steps in helping the people in the state of Michigan to be better informed in the area of family life and sex education. You are to be commended.

Yours very truly,
Esther D. Schulz, Ph.D.
Associate Director for
Educational Services
Sex Information and Education
Council of the U.S.

Sees Value of State Medical Journals Increasing In Future

BY GEORGE F. LULL, M.D.,
EXECUTIVE SECRETARY,
ILLINOIS MEDICAL SOCIETY

The state medical society journals, I firmly believe, will be of even greater value in the future.

Let me explain some of the reasons for my contention. The state medical society journals in coming years will provide more essential information to physicians in such areas of growing importance as socio-economics and legislation.

This is based on the presence of so many socioeconomic factors in the physician's daily practice—be he generalist or specialist. Many of these factors have political and economic import of a specific kind peculiar to the state in which the physician lives. There was very little political activity among physicians years ago, but it is different now.

WITH HUNDREDS OF bills concerning health and medical practice being introduced in our legislatures and these being compounded on the national level, the physician must be kept informed and the state journal is one medium that is very valuable for this purpose. Should adverse legislation be introduced, the doctor may have a lot of influence with his local representative or Congressman in explaining why such legislation should not be made into law. To do this the doctor must be informed and the journal can do a good job in keeping the physician informed.

When legislation is passed it often has to be explained to society members and there the journals can go into high gear. When the recent Medicare bill became law, its administration differed in the various states, however, no state knew just how to start without guidelines and the law was operative before the details were furnished from Washington. Many questions arose about fees and the members of the state society had to be told what negotiating with the department of public aid had resulted in the way of answers. Medical details in each state had to be explained in the state medical journals.

Let me suggest several other reasons why state medical journals are important.

THE STATE JOURNALS in some instances may be a good training ground for young writers. These men may have scientific articles, book reviews, even editorials that are worthwhile. They need only a little encouragement and this may be of a great deal of importance in their development.

The physician, as a rule, is interested in what happens to his colleagues in the state,—who died, who was elected to office, who was given an award, etc. There is no better place for this material except in his state journal. These items take up little space, but a large percentage of the readers look for them first.

The state journal can be of a great deal of service as an historical document. It is surprising how many important facts, some more so than others, are lost.

AS I LOOK AT THE state medical journal, it is my opinion that it was of much more value to the members in the past than it is at present. However, I visualize the time in the near future when it will be of a great deal more value. I am convinced that the state medical journal definitely deserves a place in the overall field of medical journalism.

I am sure that there will be a need for some kind of professional journal either for each state or for a group of states for a long time in the future.

BOOK REVIEWS

DEVELOPMENT OF THE LUNG, CIBA FOUNDATION SYMPOSIUM. Edited by A.V.S. De Reuck and Ruth Porter. $13.00 Little, Brown and Company, Boston, 1967.

This book is based on a symposium held in London on November 1st to 3rd, 1965. Its members were twenty-five distinguished pediatricians, physiologists, anatomists, biochemists, physical chemists, and zoologists from varying parts of Europe and the U.S.A. The purpose of the symposium was to explore the physiological problems that animals faced in the development of the lung when they evolved from water to air breathing and to relate these to the problems of the human fetus as it progresses from liquid filled lungs to air breathing at birth. It is an unique approach, and although the analogy may be a bit obscure, there is much to recommend this book.

The symposium consisted of eighteen presentations, each followed by a discussion from the entire group. It starts with a discussion of gas transport between the environment and cell and includes an interesting discussion of changes in pH with changes in temperature of the animal. The concept is presented of [OH —]/[H +] constancy as an explanation for the increase in arterial pH with decrease in temperature. In subsequent presentations there are discussions of the changes in respiratory function as animals moved from water breathing to air breathing. It is interesting that in amphibians the skin seems to have an important function in removing CO_2. The embryology, postnatal development and alveolar surface lining layer of the lung are described. In this section are some interesting electron micrographs. Intrauterine gas exchange is then considered. Some contributors noted that the O_2 affinity of fetal hemoglobin is little or no different from maternal hemoglobin. The previously reported differences were felt to be due to pH effect. The initiation of respiration, the pulmonary circulation in the fetus and new born, and the uptake of liquid from the lungs at birth are next discussed. Data are presented suggesting that much of the lung liquid in the lamb is removed by the lymphatics with the onset of respiration.

The discussions following each presentation are well edited and bring up many fascinating subjects. For example, the question is raised whether chickens can hatch at high altitude because of the limitation of O_2 diffusion through the shell. The conclusion seems to be that adaptive mechanisms have allowed chickens to be born at high altitudes but that eggs will not hatch following abrupt change from low to high altitudes. Another interesting discussion is concerned with oxygen consumption in diving seals.

This book is well worth reading and should be of interest to pulmonary physiologists and neonatologists or anybody with curiosity about respiratory development and adaptation.

William F. Howatt, M.D.
Associate Professor of Pediatrics
University of Michigan
Ann Arbor, Michigan

DIABETES MELLITUS: DIAGNOSIS AND TREATMENT, VOLUME II. Edited by George J. Hamwi and T. S. Danowski. 250 pp. $2.50 American Diabetes Association, Inc., New York, 1967.

The first volume of *Diabetes Mellitus: Diagnosis and Treatment* was published in 1964. It was stated that this was an effort to provide practical, concise and up to date information to a large number of physicians. The second volume contains many new titles as well as authors not found in the first volume. Quite correctly, one can state that each complements the other with a minimum amount of duplication.

One of the strongest features of this very excellent book is the brevity with which the authors have been able to convey a great deal of information. Both editors and authors are to be congratulated for being able to cover their subjects in chapters that average about five pages each. Some of the titles of the chapters indicate the range of this new volume. The following are examples: Recent Research Interests in Diabetes, The Genetics of Diabetes Mellitus, A Differential Diagnosis of Hyperglycemic States, The Clinical Use of the Various Insulins, and Pregnancy and Diabetes Mellitus. There are a total of forty-two chapters in the text. It would be difficult to single out any one of them as being superior to others. Two sections of the book which probably will be found very helpful to the practicing physician are entitled, Emergencies and Long Term Problems. These are covered in much greater detail than in the first volume published three years ago.

The authors frequently express their own personal philosophies concerning the approach to a particular problem. In most instances the reason for a particular approach is very well outlined. In a book of such brevity, alternate courses obviously could not be given in much detail. This reviewer, however, felt that this was not truly a fault of the text since it is primarily designed for the non-specialist in the field of diabetes mellitus.

I would emphasize, however, that the specialist can use this text to his benefit as a quick review and an accurate presentation of our present knowledge in this field.

Finally, the publishers are to be congratulated on making the volume available at such an inexpensive price. In spite of this, the book is well constructed, contains adequate references at the ends of most chapters and has a very complex index. It can be highly recommended.

George H. Lowrey, M.D.

NEW BOOK ON ALCOHOLISM AVAILABLE FROM AMA

The new Manual on Alcoholism has been published by the American Medical Association and provides practical medical guidelines.

In 87 pages, the AMA's new manual defines alcoholism and sets out its causes. It tells what an alcoholic is and is not, and what physicians can do to help him.

Thirteen authorities submitted resource information for the manual, which was edited by Robert J. Shearer, M.D., former associate director of the AMA Department of Mental Health, and approved by the AMA Council on Mental Health and its Committee on Alcoholism and Drug Dependence.

The manual is available from the Order Handling Unit, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610. Prices are 50 cents a copy in the U.S., its possessions, Mexico, and Canada (40 cents a copy for medical students, interns and residents in those countries), and 60 cents in all other countries.

MSMS BOOKLET DISPLAYED AT AMA INSTITUTE

Among the publications on display at the AMA Communications Institute was the MSMS booklet *"The American Economic Scene at Mid-Century."* The publication is a collection of socio-economic articles, originally published in *Michigan Medicine.* Articles were written by Clyde T. Hardwick, Ph.D., who is the economic consultant to MSMS. Professor Hardwick is Associate Dean of the College of Commerce at The University of Detroit.

Copies of the 18-page booklet are available from MSMS, 120 West Saginaw, East Lansing 48823.

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IN MEMORIAM

L. R. Atler, M.D., Detroit

Lawrence R. Atler, M.D., Detroit physician, died November 14 at the age of 68. He had practiced medicine in Detroit for 40 years.

Born in Detroit, he was graduated from the Detroit College of Medicine in 1926. Doctor Atler was affiliated with Grace Central Hospital.

He was a member of the Intercollegiate Club of Detroit and Phi Delta Epsilon medical fraternity.

Oliver W. Lohr, M.D., Saginaw

Oliver W. Lohr, M.D., noted Saginaw pathologist, died October 25. He was 73.

Doctor Lohr was born in Pittsburgh, Pennsylvania, attended high school in Berrien Springs, and received his M.D. degree at Washington University, St. Louis, Missouri, in 1921. During World War I he served at the Base Hospital, Rouen, France.

The first pathologist in the Saginaw Valley, he started out serving all three area hospitals and was pathology chief for many years at St. Mary's Hospital, Saginaw, until 1957. He was also affiliated with the Saginaw Veterans Hospital. He opened his own Central Laboratory in 1922 and operated it until 1961.

Doctor Lohr was a past president of the Saginaw County Medical Society and a Life Member of MSMS. He was once president of the Michigan Pathological Society and was a member of the American Society of Clinical Pathologists, the American College of Physicians, the American Heart Association, the American Public Health Association and the American Cancer Society. His medical fraternity was Alpha Omega Alpha.

Active in cultural affairs, he had been president of the Community Concert Association. He was also a past president of the Saginaw Valley Torch Club and a leader in the Rotary Club.

One of the survivors is his son, Thomas O. Lohr, M.D., of Saginaw.

E. E. Poos, M.D., Detroit

Edgar E. Poos, M.D., Detroit eye, ear, nose and throat surgeon, died September 22 at the age of 73.

Doctor Poos received his M.D. degree from St. Louis University, having done his pre-medical work at McKendree College, Lebanon, Illinois.

During World War I he attained the rank of Lieutenant Colonel as a medical officer. Following his internship and residency in otolaryngology at St. Louis City Hospital, St. Louis, Missouri, he began practice in Detroit.

He was a Life Member of the Wayne State Medical Society, Michigan State Medical Society, American Medical Society, Board of Otolaryngology, American College of Surgeons, International College of Surgeons, and Masons, and held fellowships in several other professional organizations. He was a graduate flight surgeon and examiner for United Airlines.

Postgraduate studies and clinics took him to Vienna, London, Bordeaux, Montpelier, New York, St. Louis, Chicago, Cincinnati, Boston, Indianapolis, Ann Arbor and Detroit.

He was affiliated with Highland Park General Hospital, Mt. Carmel Mercy Hospital, Grace Hospital, Hutzel Hospital and Detroit General Hospital.

E. C. Sites, M.D., Port Huron

Edgar C. Sites, M.D., Port Huron surgeon and civic leader, died November 7 of injuries received in an automobile accident. He was 75.

Graduated from Valparaiso University in 1915 with an A.B. degree, he entered the teaching profession. He was a school principal in Francesville, Indiana, until World War I, during which he served in the U.S. Army, rising to the rank of captain.

After the war, he entered Indiana University Medical School and received his M.D. degree, cum laude, in 1923. He spent another year at Indiana University doing postgraduate research. His internship and further studies were done at Henry Ford Hospital in Detroit. In 1927 he moved to Port Huron where he practiced for the past forty years. He was to retire the week of his death.

For the past 16 years, he was president of the St. Clair County Health Department. He was the first chief of staff of Mercy Hospital, which he helped establish and continued to serve as a member of the Advisory Board. He had also been chief of staff of the Port Huron Hospital.

A past president of the St. Clair Medical Society, he was honored in 1959 by fellow physicians for his contributions to the advancement of medicine in the area, his promotion of annual clinic days and his assistance to young doctors beginning practice.

Doctor Sites was a member of the Port Huron District Foundation and of the St. Clair County

Community College Foundation, and had recently received a pin for 18 years of perfect attendance from the Port Huron Rotary Club.

He was a Fellow of the American College of Surgeons and a regent of the Midwest Area of the Fellowship of the International College of Surgeons. He was a member of the Society of Abdominal Surgeons and Alpha Omega Alpha and Phi Chi medical fraternities.

C. G. Wencke, M.D., Battle Creek

Carl G. Wencke, M.D., retired Battle Creek otolaryngologist, died November 11 at the age of 78. He had practiced in Battle Creek for 50 years.

Born in Lawrenceberg, Indiana, he attended the former American Medical Missionary College in Battle Creek for two years and completed his M.D. degree at the University of Illinois in 1914. After graduation he returned to Battle Creek and joined the staff of the Battle Creek Sanitarium Hospital where he remained until 1936, interrupted only by service in World War I and by postgraduate study at the University of Illinois, the University of Pennsylvania in 1921-22, and the University of Vienna, Austria, in 1926. He headed the ENT department of the hospital from 1930 to 1936. In 1936, he opened private practice which he continued until his retirement in 1964. In that year, he was awarded a 50-year service pin from the Michigan State Medical Society.

Doctor Wencke was a charter member of the U.S. Army Ambulance Service, having served from 1917-1919 in an ambulance company in Italy. In the Army, he rose to the rank of captain and was decorated by the Italian government with the Cavalier Award.

He served as president of the Southwestern Michigan Trilogical Society in 1938. A past president of the Calhoun County Medical Society and a Life Member of MSMS, Doctor Wencke was a member of the American Academy of Otolaryngology and a Fellow of the American Otorhinologic Society for Plastic and Reconstructive Surgery and the American College of Surgeons. He was a past president of the Battle Creek Kiwanis Club and a 32nd degree Mason.

D. R. Wright, M.D., Flint

Donald R. Wright, M.D., Flint, former president of the American Proctology Society, died November 17, He was 72.

A 1923 graduate of the University of Michigan Medical School, he began practice in Flint in 1924. He had served during World War I in France at Base Hospital #17, AEF.

Doctor Wright was a former president of the Genesee County Medical Society, the Flint Academy of Surgery and the American Proctology Society. He was an honorary member of Galeas and a member of Phi Chi medical fraternity.

He was a past president of the Flint Downtown Optimist Club and a member of the U-M Club of Flint, the U-M Alumni Association, the Elks, and Lakeside Lodge 371, F&AM.

Midland policemen and firemen watch a demonstration in the correct use of the respirator.

NEW ARTIFICIAL RESPIRATORS IN USE AT MIDLAND

"If these units save one life in five years, they will be well worth the cost," commented Sidney Smock, M.D., anesthesiologist at Midland Hospital, during a recent training session for City employees in the use of a new kind of artificial respirator.

Midland has purchased 23 of the simply-constructed, breathing aids for emergency use in public places. They have been placed in police cars and fire trucks and other city vehicles, and plans call for putting them in ambulances, public school gymnasiums, swimming pools, and doctor's offices.

"Completely safe for any individual, there is no device more effective for artificial respiration," doctor Smock said.

The respirator is useful whenever a person is not breathing, or not breathing properly. Doctor Smock points out that the unit, which uses natural air, will be useful in most emergency situations except for smoke inhalation and gas contaminated air cases when pure oxygen is needed.

Roy M. Goethe, M.D., president of the Midland County Medical Society, praised the resuscitators because they are "small, convenient, and spread all over town for immediate use." "Wherever they have been placed," Doctor Goethe added, "the people in charge have been trained to use them by a physician."

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> —Charles Shuman, President
> American Farm Bureau

Offer International Vaccination Memo:

An advisory memorandum on International Certificates of Vaccination has been issued by the Michigan Department of Public Health and will be of interest to MSMS members.

The MDPH memorandum quotes the Chief, Epidemiology and Research Analysis Section, Foreign Quarantine Program, U. S. Department of Health, Education and Welfare, National Communicable Disease Center, Atlanta, Georgia. It states:

"The Committee on International Quarantine in its Third Report (Official Records of the World Health Organization—No. 72, page 49) made several recommendations to answer certain questions referred or sumbitted to the World Health Organization in respect to the International Certificates of Vaccination. Because of the frequency of similar questions, you may find the Committee's statements helpful.

"(1) Only qualified medical practitioners should sign vaccination certificates.

"(2) Vaccinations may be carried out by nurses and medical technicians if under the direct supervision of a qualified medical practitioner.

"(3) A medical practitioner is required to sign the certificate in his own handwriting; his official stamp is not an accepted substitute for his signature.

"(4) As indicated in Appendix 4 (of the International Sanitary Regulations), the result of a primary smallpox vaccination must be recorded.

"(5) When a baby born to a mother immunized against smallpox has an unsuccessful primary vaccination, the unsuccessful result should be recorded.

"(6) A parent or guardian should sign the international certificate of vaccination when the child is unable to write. The signature of an illiterate should be indicated in the usual manner by his mark and the indication by another that this is the mark of the individual."

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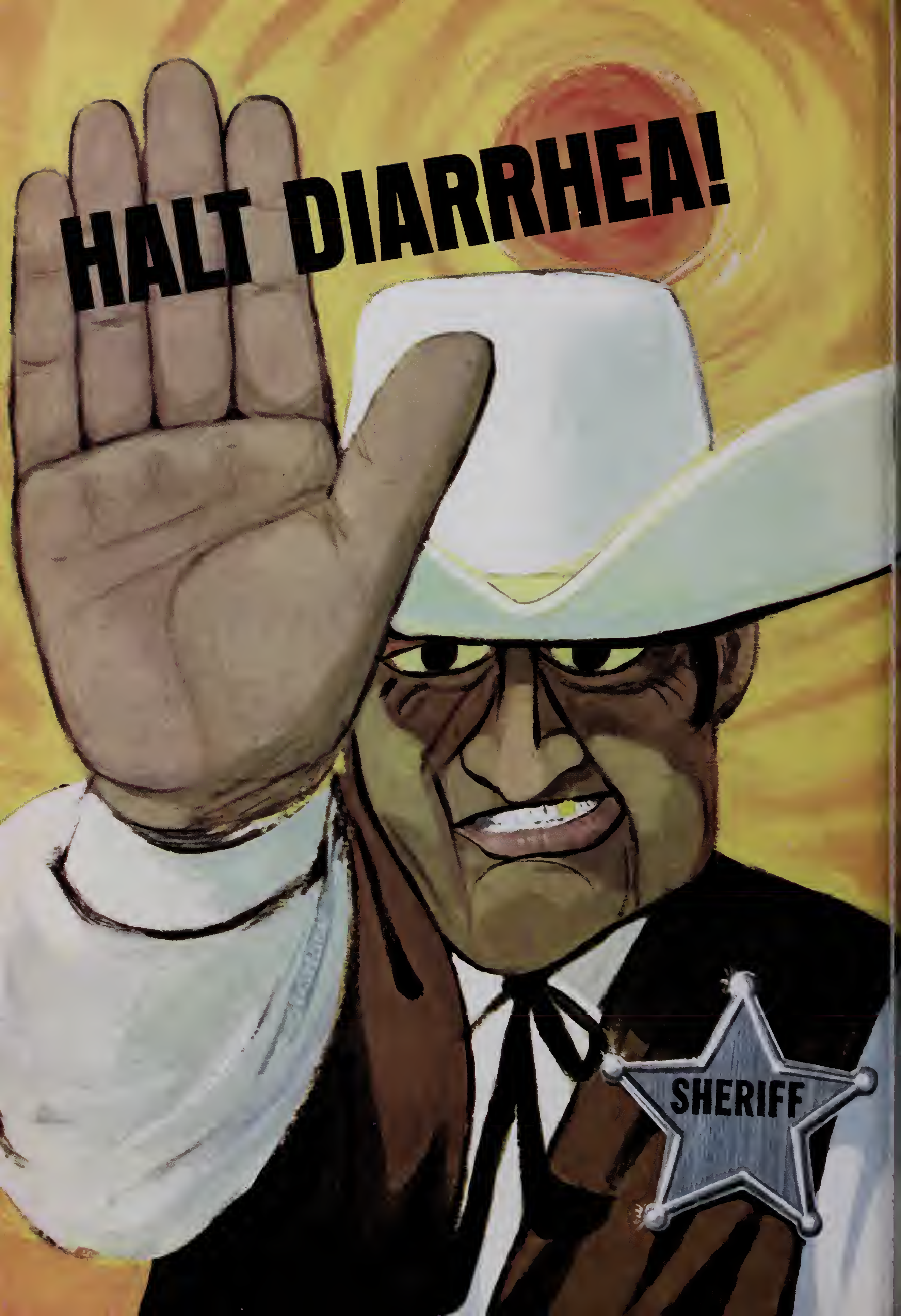
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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ....2.5 mg.
(Warning: may be habit forming)
atropine sulfate ....0.025 mg.

Halts Diarrhea Promptly

in children with . . . Gastroenteritis ▪ Spastic bowel Influenza-like infections ▪ Antibiotic-induced diarrhea

omotil helps get children with diarrhea off toast and tea and back to normal iets and normal activity with gratifying dispatch. ▪ Lomotil lowers intestinal otility and permits absorption of excess fluid. This usually controls diarrhea romptly. ▪ Moreover, lowered intestinal motility achieved with Lomotil often elieves the abdominal cramps and discomfort so distressing to children.

recautions: Lomotil is a Federally exempt arcotic preparation of very low addictive otential. Recommended dosages should ot be exceeded, and medication should be ept out of reach of children. Should accilental overdosage occur signs may include evere respiratory depression, flushing, ethargy or coma, hypotonic reflexes, nysagmus, pinpoint pupils, tachycardia; ontinuous observation is recommended. omotil should be used with caution in paients with impaired liver function or those aking addicting drugs or barbiturates.

ide Effects: Side effects are relatively unommon but among those reported are astrointestinal irritation, sedation, dizziess, cutaneous manifestations, rest- essness, insomnia, numbness of the xtremities, headache, blurring of vision, welling of the gums, euphoria, depression nd general malaise.

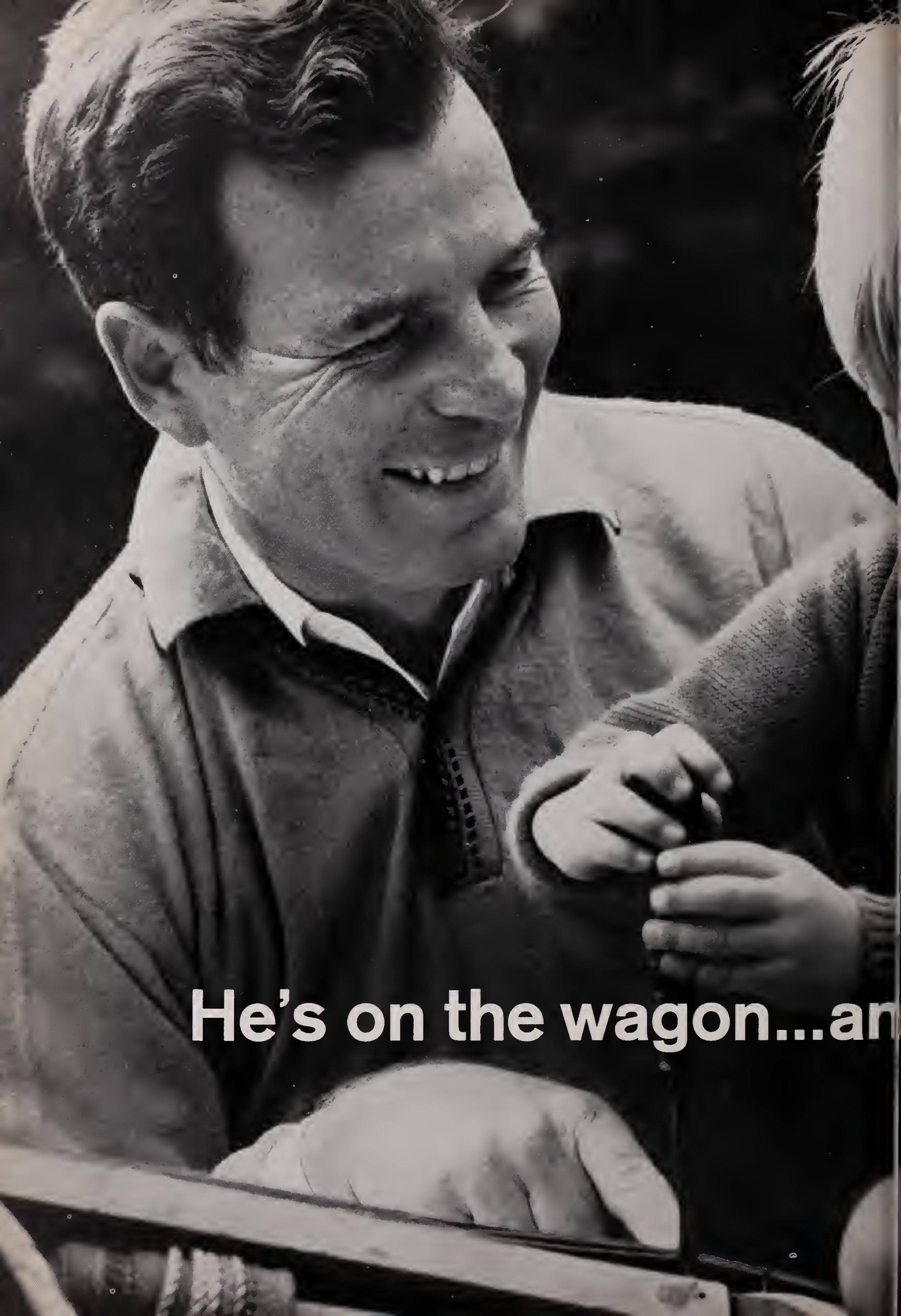
Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage
3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE *Research in the Service of Medicine*



He’s on the wagon...an

w well does Vistaril relieve the symptoms that
gue an alcoholic during the recovery period?
ctors Knott and Beard of the Alcoholic Reha-
tation Unit, Tennessee Psychiatric Hospital
l Institute, recently conducted a double-blind
dy comparing Vistaril and another well-
ablished antianxiety agent with placebo in 60
onic alcoholic patients.[1]
e investigators conclude: "It was the opinion
he staff that hydroxyzine was generally more
ective than chlordiazepoxide, for the follow-
reasons: hydroxyzine was equally if not more
ective in reducing anxiety and tension and it
duced less daytime sedation...."[1] (See results
succeeding pages.)
re is new evidence that Vistaril can ease ten-
n, allay anxiety in chronic, hospitalized alco-
ic patients. *But you might also choose Vistaril*
what it doesn't do. Although not evaluated in
s study, Vistaril is reported to be non-euphor-
t, and its low toxicity makes it relatively safe.
st of all, Vistaril is non-habituating. To date,
er more than ten years of clinical use, there
e been no reports of dependency in patients
eiving Vistaril.

th Vistaril, it is as easy to
op therapy as it is to start.

Vistaril®
HYDROXYZINE
PAMOATE)

ASE SEE LAST PAGE FOR PRESCRIBING INFORMATION

the study:[1] Sixty chronic alcoholic patients were hospitalized and randomly assigned to one of three oral double-blind treatment regimens for three weeks. Twenty patients received hydroxyzine (Vistaril®), 100 mg. q.i.d.; twenty others were given chlordiazepoxide, 25 mg. q.i.d.; and the remaining twenty received placebo capsules q.i.d. The capsule code was not made known until after completion of the study and analysis of the data. Response was measured with a modification of the Brief Psychiatric Rating Scale as originally outlined by Overall and Gorham.* Subjects were rated daily by trained staff members.

SYMPTOM RATING KEY

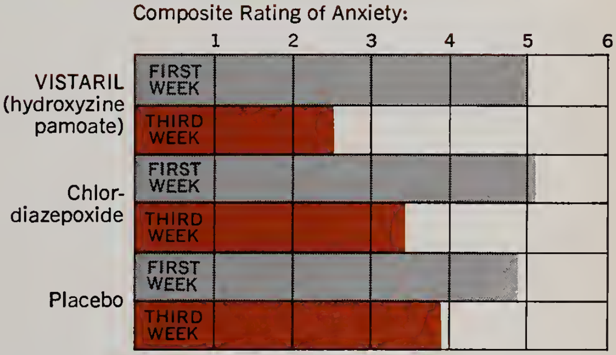
1=Not Present
2=Mild
3=Moderate
4=Moderately Severe
5=Severe
6=Extremely Severe

The figures which are given below represent the composite conclusions of the staff based on daily ratings during initial and final weeks of the study.

*Psychological Reports 10:799, 1962

the results[1] ▨ DURING FIRST WEEK 🟥 DURING THIRD WEEK

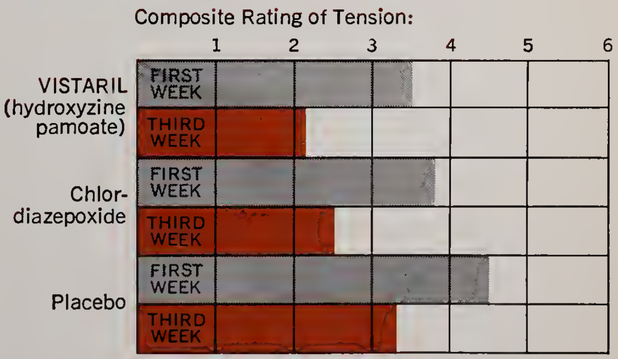
Anxiety reduced with Vistaril



OVERALL REDUCTION OF ANXIETY (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
50%	33%	20%

Tension eased with Vistaril



OVERALL REDUCTION OF TENSION (%)

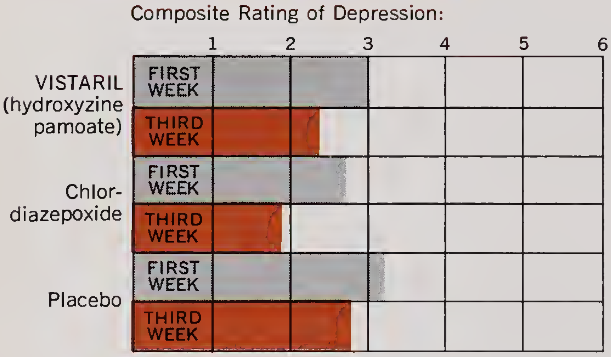
VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
40%	34%	27%

In Alcoholism...

"Both hydroxyzine and chlordiazepoxide were generally more effective than the placebo. In some aspects, hydroxyzine was superior to chlordiazepoxide, which is currently the most frequently used psychotropic drug in the management of alcoholism."[1]

▨ DURING FIRST WEEK 🟥 DURING THIRD WEEK

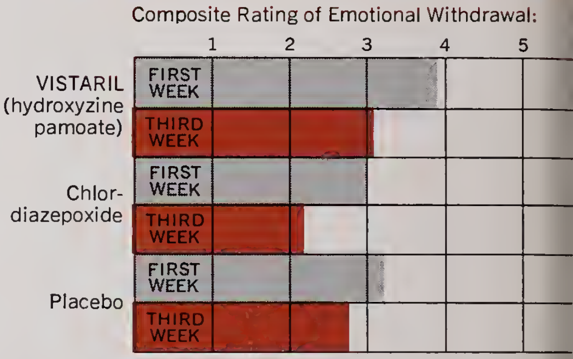
Depressive mood improved with chlordiazepoxide



OVERALL IMPROVEMENT IN DEPRESSIVE MOOD (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
20%	30%	13%

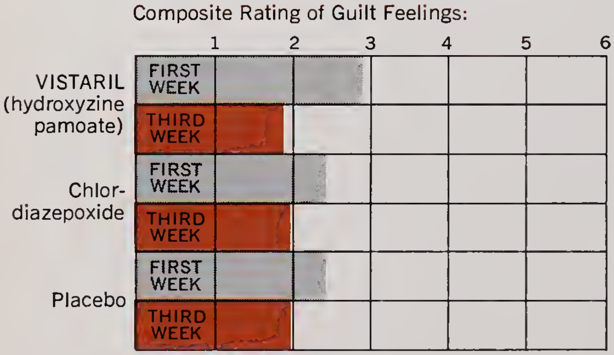
Emotional withdrawal counter-acted with chlordiazepoxide



OVERALL IMPROVEMENT IN EMOTIONAL WITHDRAWAL (

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Place
21%	27%	13%

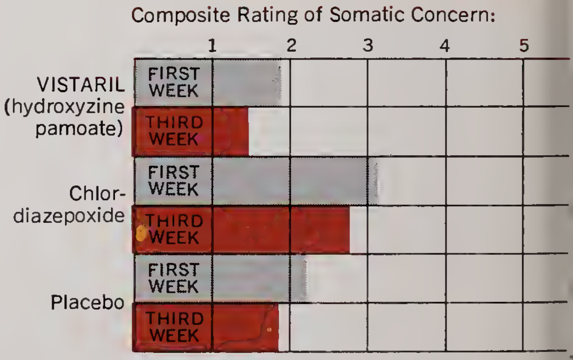
Guilt feelings allayed with Vistaril



OVERALL DECREASE IN GUILT FEELINGS (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
34%	17%	17%

Somatic concern alleviated to minor degree in each group



OVERALL ALLEVIATION OF SOMATIC CONCERN (%)

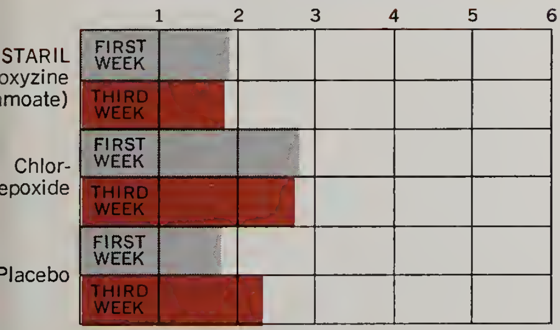
VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Plac
17%	13%	14

Less drowsiness with Vistaril

	Drowsiness	Dizziness	Mouth Dryness	Increased Motor Activity	Ataxia	Nausea	Comments
VISTARIL (hydroxyzine pamoate)	6 patients (mild)	3 patients (mild)	2 patients (moderate)	—	—	—	Side Effects Not Treate
Chlor-diazepoxide	10 patients (severe in 6)	4 patients (mild)	—	1 patient (moderately severe in first week but gradually subsided)	—	—	Side Effects Not Treate
Placebo	2 patients (mild)	2 patients (mild)	—	—	1 patient (mild)	2 patients (mild)	Side Effects Not Treate

ncrease in hostility minimized h Vistaril and chlordiazepoxide

Composite Rating of Hostility:

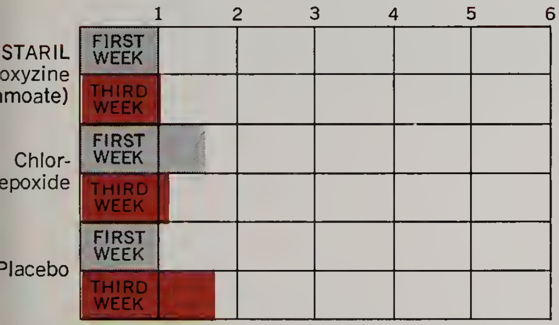


ALL CHANGE IN HOSTILITY (%)

ARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
5%	4%	—28%

operativeness not a significant problem

Composite Rating of Uncooperativeness:



ALL CHANGES IN COOPERATIVENESS (%)

ARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
No change	31%	—70%

Alcoholism...

Vistaril®

HYDROXYZINE PAMOATE)

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

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MICHIGAN MEDICINE

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VIETNAM: THE OTHER WAR

See Page 248 for the Story of Michigan "Volunteer Physicians for Vietnam"

MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 3
FEBRUARY, 1968

AMONG THE IMPORTANT ARTICLES:

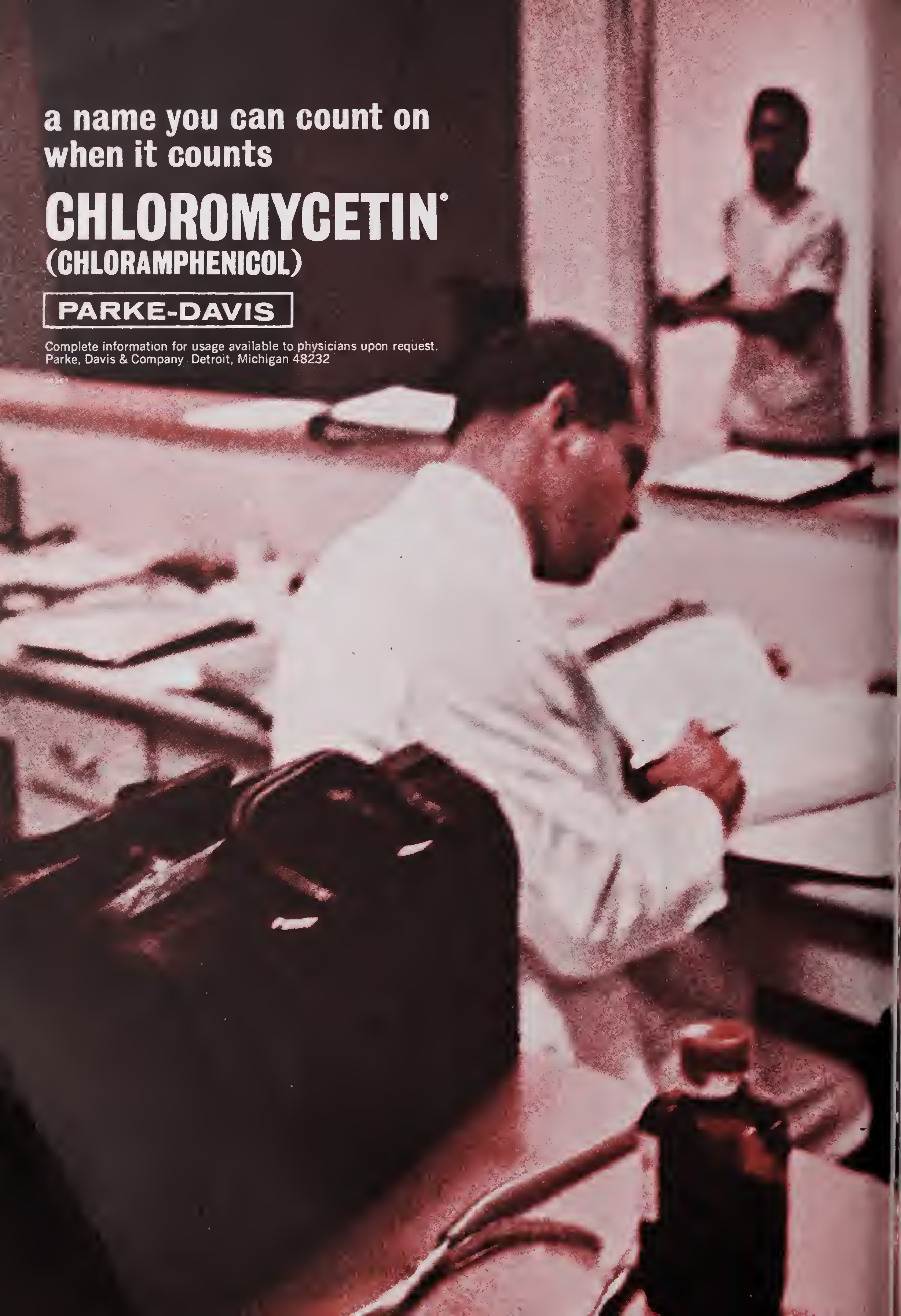
Lap Seat Belt Injuries:
The Treatment of the Fortunate Survivor

Where Does MSMS Stand re Legislation?

Reactions Wanted to Manpower Proposals

Four Targets Need More Health Education

SEE 227 — MSMS FEBRUARY CONFERENCES



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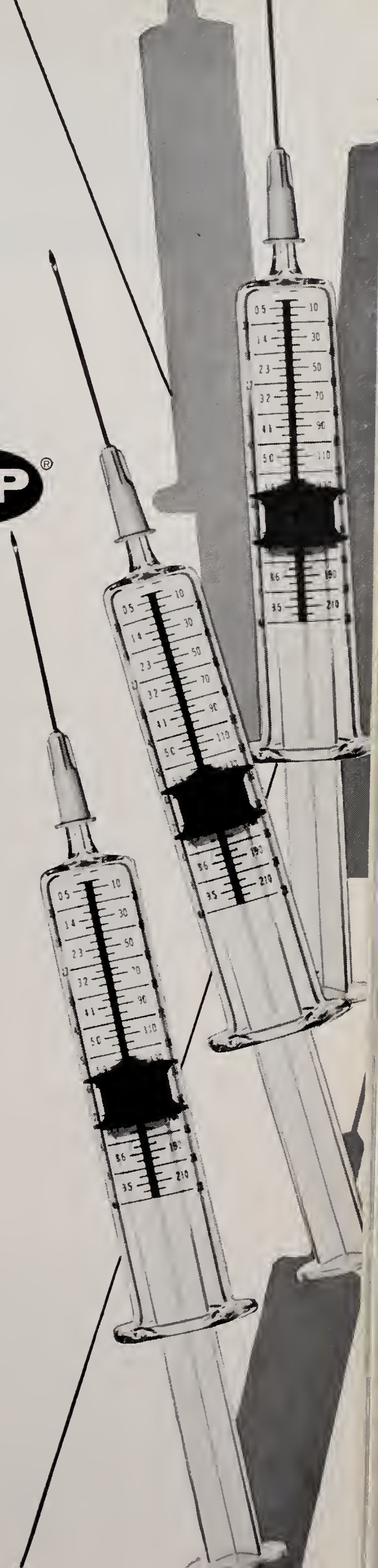

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ABOUT THE COVER

The cover calls attention to a feature article about Michigan doctors of medicine who have volunteered to serve in Vietnam. The photos were provided by the AMA Science News Department of doctors serving in the "AMA Volunteer Physicians for Vietnam Program" in the Mekong Delta region and with the Montagnards in the Central Highlands. See Page 248.

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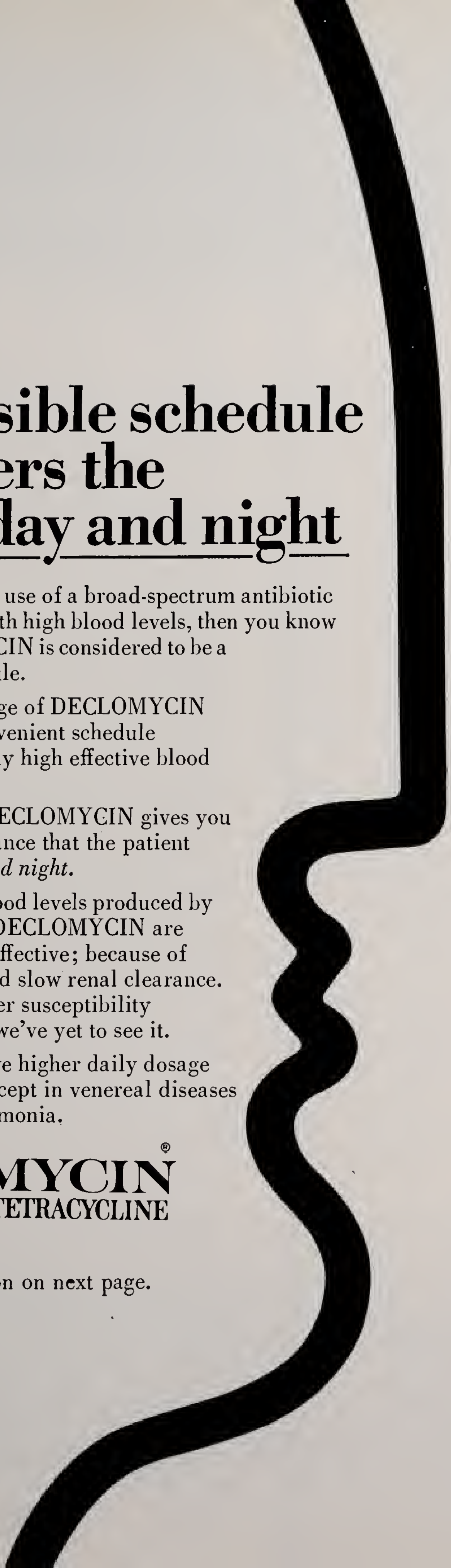

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Prescribing information on next page.

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DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

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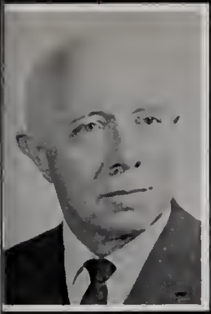

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Four Targets Need More Health Education

Individual doctors, county medical societies and MSMS need to work to increase and improve their efforts in health education to upgrade understanding of four critical community problems.

These four major concerns have been identified as targets by the AMA Department of Health Education.

THE FOUR AREAS—already the object of considerable MSMS effort—are listed as:

"1. Sex education, or the broader concept of education for sexuality which includes interpersonal relations as well as sexual anatomy and physiology;

"2. The control of syphilis and gonorrhea through case-finding and specific therapy;

"3. Education for family living with emphasis on family health protection;

"4. Education that may prevent or control habituation to such noxious or toxic substances as heroin, barbiturates, and other drugs, marihuana, tobacco, alcohol, and the volatile substances used in glue sniffing."

Health education in the community must be a major dedicated purpose and function of the county medical societies and its committees.

The county societies have a responsibility to their communities to cooperate and assist the schools, voluntary civic organizations, health-related associations, and the official agencies.

FIVE BASIC QUESTIONS can help serve as guidelines by the county societies and its leaders. The officers, chairmen and members must ask:

1. Who will do the job?
2. When will the job get done?
3. What problem needs solving?
4. Toward what target population is the educational effort to be directed?
5. What are others doing about the problem?

After these questions are carefully researched, then the county medical society should plan and develop a program of action.

Health education is not easy. Evaluation must be continuous. The programs must be more than "noise." The measurement of success must be changes in attitudes and habits by the target population.

SUCCESSFUL ACTION programs usually incorporate many elements. Educational efforts usually involve MD efforts through schools and through community groups. Doctors have ready-made opportunities to serve as consultants for study units and for community service projects. The local news media should be brought into the team effort because they can conduct effective informational efforts and help change attitudes.

MSMS—AND THE AMA—are able and ready to help implement vital health education activities.

Physicians every day do carry out their responsibilities for health education in the privacy of their consultation rooms. This cannot be enough. Physicians both individually and collectively as medical societies have a responsibility to their community.

The opportunities are unique.

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Lap Seat Belt Injuries;
The Treatment of the Fortunate Survivor

BY RICHARD C. SCHNEIDER, M.D.
WILLIAM S. SMITH, M.D.
WILLIAM C. GRABB, M.D.
JEREMIAH G. TURCOTTE, M.D.
DONALD F. HUELKE, Ph.D.
ALL OF ANN ARBOR

ABSTRACT — The lap seat belt has prevented many traffic fatalities during the past decade. With the use of this protective device, however, certain characteristic traumatic lesions have occurred in some cases. A multidisciplined approach to their treatment and the possible prevention of such injuries by a combination of the cross-chest strap and lap seat belt is presented.

This multidisciplined clinical study is from the University of Michigan Highway Safety Research Institute. The study was supported by a grant made by Alvin M. Bentley and in part by USPHS grant UI-00008 from the Injury Control Program, National Center for Urban and Industrial Health.

Much of the initial data on occupant kinematics and injury reduction has been collected from simulated accidents employing dummies or cadavers as car occupants. At our institution on-the-scene investigations of fatal automobile accidents have been conducted, correlating the fatal injuries with the objects that produced these fatalities (ejection, steering, assembly, instrument panel, etc.) [15,16,18,19,20] and the pathologic findings in the fatally injured.

The present review was undertaken because there are few reports available which describe the special problems of persons wearing lap belts who survive accidents. A well-coordinated, multidisciplined team of physicians should provide not only treatment for the injured in such traffic accidents, but also assemble significant clinical data for research purposes as an aid to future injury preventative measures.

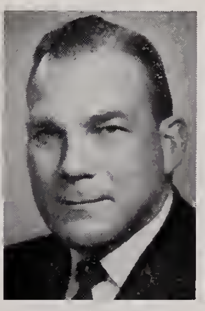
LAP SEAT BELTS have been proven effective in preventing many serious and fatal injuries.[1,2,3,11,12,13,23,27,42,45,46]

However, it is possible that a new protective device preventing one type of injury or fatality may cause undue stresses in other body areas producing different traumatic lesions. Sporadic reports have appeared in the literature related to seat belt injuries[5,6,8,9,10,14,17,22,24,26,32,33,37,41,44]; the most comprehensive review being presented by Snyder, et al.[38]

At the outset it must be emphasized that this article is written not to condemn lap seat belts but to advocate them, for without these safety measures more serious injuries and fa-

CO-AUTHORS

SCHNEIDER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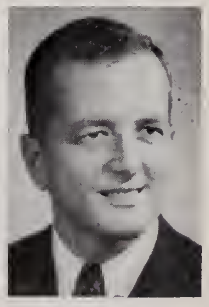
GRABB

TURCOTTE

HUELKE

From the University of Michigan Medical School, Department of Surgery: Dr. Schneider, Section of Neurosurgery; Dr. Smith, Section of Orthopedic Surgery; Dr. Grabb, Section of Plastic Surgery; Dr. Turcotte, Section of General Surgery. Dr. Huelke is a member of the Department of Anatomy.

talities would occur in automobile collisions.[20,46]

The substitution of a shoulder-lap belt combination[3,13,28,34,36] for only the single lap seat belt is gradually evolving as the next step forward which the public must take to afford further protection. Indeed, one may face the possible appearance of different important sequelae with this innovation, but like the use of lap seat belts, it should not be a deterrent from a shift toward improved safety equipment. Cooperative studies by the physician, automotive engineer, and highway safety teams must continue and be expanded.

FIVE CASE REPORTS of patients with injuries from automobile mishaps are presented to illustrate certain types of lesions which may be associated with the use of lap seat belts.

Because of the specific mechanisms involved, the investigation of these principles by the team approach provides a better understanding of the type of treatment which is necessary and the best opportunity for full recovery of that patient.

CASE REPORTS

Cervical Spine Fracture And Vocal Cord Paralysis

Case 1: [32*] R.M., a young millworker, was admitted to the hospital on June 5, 1962, having been injured 42 hours previously in a two-car collision. He was wearing a lap seat belt. Although stunned, he was not unconscious and recalled that his head had flexed acutely forward resulting in the steering wheel catching him beneath the chin (Fig. 1A). Immediately after the injury, his respirations were very labored with stridor and supraclavicular retraction. He could not speak above a whisper, and on attempting to swallow fluids a marked retropharyngeal swelling caused him to choke. There was a complete paralysis of the right vocal cord, marked paresis of the left cord, and displacement of the left arytenoid cartilage. Roentgenograms of the cervical spine demonstrated an avulsion of the neural arch of the second cervical vertebra from its body with slight disruption of the pedicles of the third cervical vertebra (Fig. 1B). A marked degree of swelling was demonstrated in the retroesophageal area at C4, C5, and C6 vertebrae.

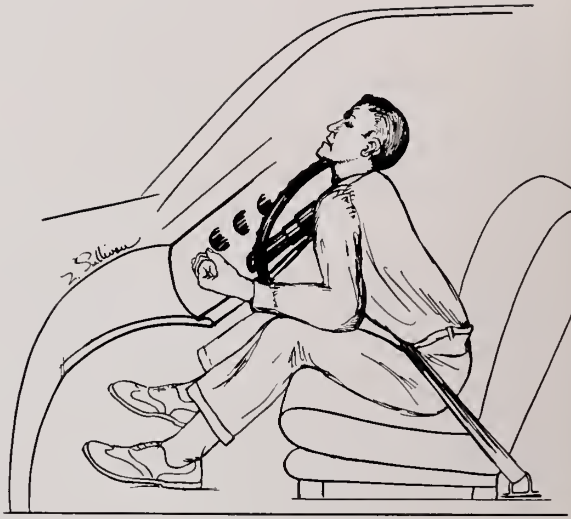

Fig. 1A:

Initially the patient sustains acute flexion of the cervical spine catching the chin on the steering wheel. The diagram demonstrates the severe hyperextension of the cervical spine, which, with the slumping of the body, provides the mechanism for the hangman's fracture.

Traction with Crutchfield skeletal tongs was applied shortly after admission to the hospital. A tracheostomy had been performed after the accident. With the exception of the above findings, there was no neurologic deficit. Skeletal traction was continued until shortly before discharge from the hospital nine weeks after injury, and a cervical brace was instituted (Fig. 1C). At this time the tracheostomy was still necessary. Subsequent laryngeal surgery was required to restore the patient's voice.

A follow-up evaluation on November 1, 1963, showed no neurologic abnormality except for slight soreness of the musculature of the neck.

Comment: The patient was originally admitted to the neurosurgical service because of his cervical spine fracture and was treated in skeletal traction as a method of stabilization. Because of his marked retropharyngeal swelling and the com-

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*Reprinted courtesy Journal of Neurosurgery, XXII, No. II, 141-154, (1965)

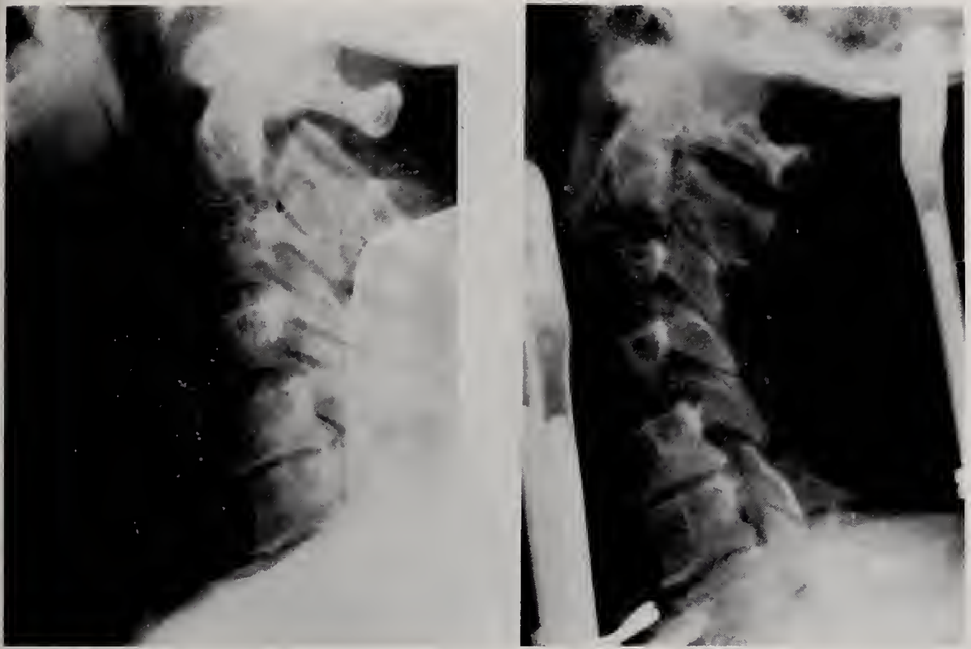


Fig. 1 (B & C).

Fig. 1B: Lateral x-rays show an avulsion of the neural arch of the 2nd cervical vertebra with slight disruption of the pedicles of the C3 vertebra. (From Schneider et al, Journal of Neurosurgery, 22, No. 2: 141-154, 1965).

Fig. 1C: Repeat cervical spine x-rays with the patient in a brace show good realignment and some healing of the fracture.

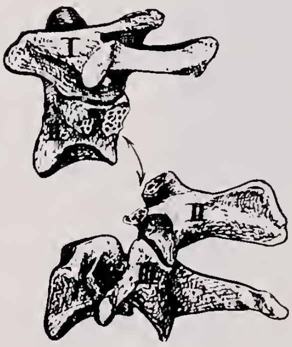
plete paralysis of his right vocal cord and paresis of the left one, it was necessary for him to have a tracheostomy. Subsequently, the otolaryngologist performed laryngeal surgery in order to restore the patient's voice.

The patient recalled flexing his forehead downward, catching his chin over the steering wheel and throwing his neck into some hyperextension. He was wearing a lap seat belt which, no doubt, prevented him from striking other parts of the interior of the car more severely but resulted in the patient "hanging" himself on the steering wheel.

In 1965, Schneider, *et al*[32] presented eight cases of traffic accidents in which the patients sustained a fracture-dislocation of C2 and C3 vertebra with a bilateral avulsion of the laminar arches from the C2 vertebral body. This injury usually was associated with little or no neurologic deficit, and the spine healed quite readily without operation as long as adequate external fixation was provided. A well fitting four-post brace worn for ten weeks is quite adequate for these purposes. This report was made by two neurosurgeons (Schneider and Livingston) working in cooperation with two British anatomists (Cave and Hamilton). The latter had observed that this highway accident injury was similar to that seen in judicial hanging where the "drop" technique was used. The lesion itself was ably described by Wood-Jones[47] (Fig. 1D) and subsequently confirmed by other authors.[43] The mechanism for the development of "hangman's fracture" is best related by quoting from the article by Schneider *et al*[32]: ". . . not only do the joints of the atlanto-axial complex confer upon the skull the requisite range of mobility (flexion, extension, rotation) but the complex itself serves also to transmit the weight of the cranium to the unmodified portion of the cervical spinal column, which begins at the third cervical vertebra.

The junction of the cervicocranium with the (so to speak) vertebral column proper constitutes a site of mechanical weakness in the spine and here the third cervical vertebra forms a fixed point. The application of such a disruptive force as that operative in judicial hanging will tend always to detach the cervicocranium from the rest of the vertebral column. The situation of the line of fracture in judicial hanging (through the neural arch of the axis or even through its body or through that of the third vertebra) is, therefore, understandable, particularly when the normal lines of transmission of cranial weight are appreciated (Fig. 1E). The weight of the skull and its contents is transmitted bilaterally through the occipital condyle, the lateral mass of the atlas, and the superior articular process of the axis, the two lines uniting in the body of the axis caudal to the base of the odontoid process. Thence, weight is transmitted farther caudally along three distinct lines, namely along the line of the vertebral bodies and discs medianly and along the line of the pre- and post-zygapophyses bilaterally. These three lines of transmission diverge from the focal point in the body of the axis already mentioned, each of the lateral lines passing through the weakest point of the neural arch of the axis which is thus predisposed to rupture in a hangman's fracture, however induced. Naturally, the sequelae of hangman's fracture can be studied only in victims of traffic accidents who have sustained such a fracture and yet have survived."

Fig. 2.



The lesion present in Captain C. F. Fraser's series of judicial hangings. Separation of the arch of the axis from the body; effect of a submental knot.

Fig. 1D:
Reprinted from article by F. Wood-Jones[47]

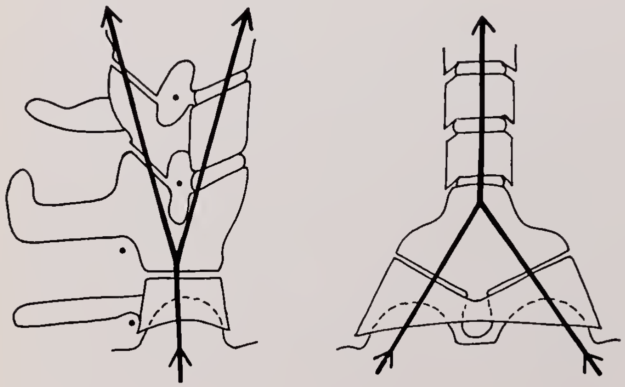


Fig. 1E:
Anterior and lateral aspects of craniocervical region to illustrate the lines of transmission of cranial weight through the atlanto-axial complex to the spinal column proper and the consequent mechanical vulnerability of the neural arch of the axis (A.J.E. Cave). (From Schneider et al, Journal of Neurosurgery, 22, No. 2: 141-154, 1965)

Perhaps some of these neck fracture patients sustain their injuries on the steering wheel or, in a similar fashion, by "hanging" themselves on the instrument panel with severe hyperextension of the cervical spine and the downward jerk of the body as it flexes forward to the floor of the vehicle.

Lumbar Spine Fracture-Dislocation And Perforation of Small Bowel

Case 2: This nine-year old, right handed girl, was involved in an automobile accident on March 4, 1966. She was thrown forward striking her head against the right side of the instrument panel rendering her transiently unconscious. This occurred in spite of the fact that she was wearing a lap seat belt. It should be emphasized that the seat belt was somewhat loosely applied. She had a headache and lower back pain. Her vital signs were normal and her pupils were equal and active. There was bilateral periorbital ecchymosis which was more marked around the left eye. She had bilateral abrasions and ecchymosis over the iliac crest and the inguinal ligaments (Fig. 2A). With the exception of the marked spasms of the abdominal musculature, originally attributed to spinal cord injury and abdominal wall contusion, there were no neurologic findings.

X-rays of the skull demonstrated a linear left frontal skull fracture (Fig. 2B). The lumbar spine films demonstrated a distraction fracture-dislocation at the L2-L3 intervertebral space with a mild compression fracture of the L3 vertebral body (Figs. 2C and 2D).

The patient was treated initially with bed rest only. Her abdominal signs disappeared and she began eating normally. Thirteen days following her injury the surgical intern noted increasing right lower quadrant tenderness. Subsequently, she became nauseated and vomited intermittently. The WBC rose to 13,500 and a flat plate and upright x-ray of the abdomen were compatible with bowel obstruction. General surgical consultation was obtained and operation was advised. At operation a point of nearly complete obstruction of the distal ileum 10 inches proximal to the ileocecal valve was found. The ilium had been injured on its mesenteric border in two adjacent areas. The obstruction was caused by a combination of scarring and adhesions of nearby loops of bowel to the site of injury. Ten inches of small bowel were resected (Turcotte) and continuity was re-established by an end-to-end anastomosis. Two-hundred ml of sterile serous fluid was aspirated from the peritoneum. Pathologic examination of

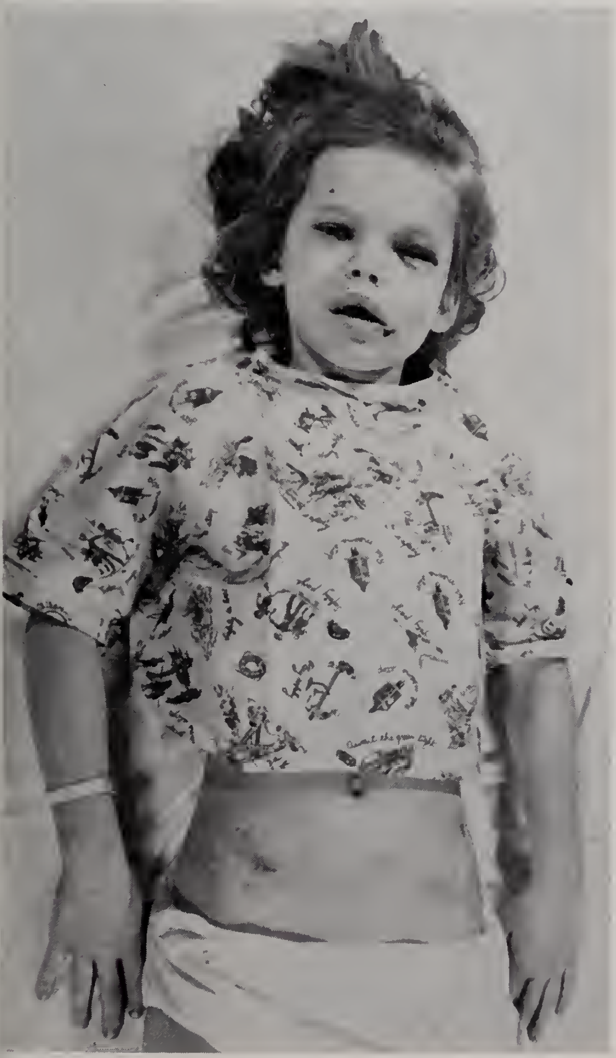


Fig. 2A.
The photograph taken a week after injury shows bilateral periorbital ecchymosis, a laceration at the left angle of the mouth, and bilateral abdominal abrasions above both iliac crests in the inguinal regions anteriorly.

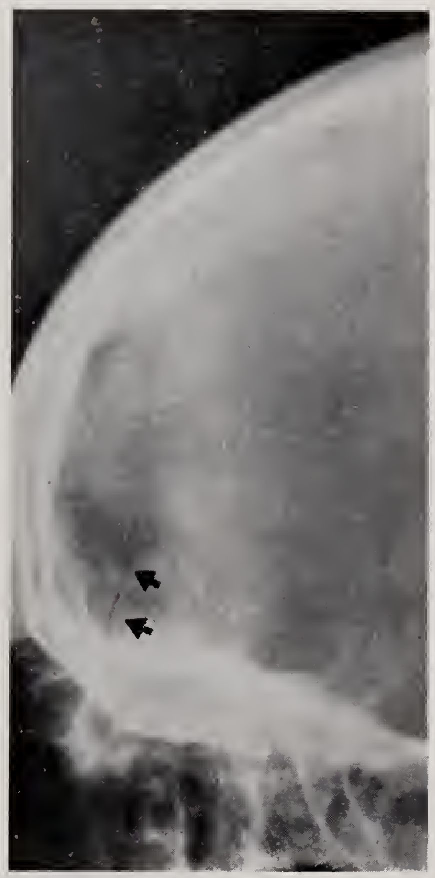


Fig. 2B.
The skull x-ray demonstrates the left linear frontal fracture.

the resected bowel demonstrated a probable site of perforation which subsequently sealed. On April 5, 1966, the orthopedic surgeon (Smith) exposed the spinal distraction fracture-dislocation site and found rupture of the interspinous ligament, rupture of the capsular ligament of the facets, rupture of the ligamentum flavum and complete dislocation of the facets. The L2-L3 interspinous distance was approximately twice normal. These spinous processes were wired together and a spinal fusion was performed using an iliac bone graft. Post-operative x-rays of the lumbar spine showed almost complete correction of the deformity (Figs. 2E and 2F). She was placed in a body cast and discharged from the hospital on April 21, 1966. At this time she was neurologically negative and asymptomatic.

Comment: This little patient had a combination of cranial, spinal, and abdominal injuries, possibly due to the fact that her seat belt was not properly tightened.[1,27] Nevertheless, this restraint very likely kept her from striking her chest and abdomen against the instrument panel, the object most frequently struck in front right passenger fatalities.

Fortunately, the skull fracture was merely a linear one in the frontal area. It was uncomplicated by any intracranial traumatic lesion. Smith and Kaufer[37] have shown that while a myriad of lesions is produced in belted individuals the only lesion that is unique to seat belt (lap) users is the pattern of the mid-lumbar spine injuries. Unlike any other lumbar spine injury it is characterized by:

1) Rupture of the interspinous ligaments, consequently widening of the interspinous space.

2) Rupture of the capsular ligaments of the facets.

3) Complete rupture of the ligamentum flavum.

4) Marked widening of the intervertebral foramina.

5) Minimal compression of the anterior-most part of the lower vertebral body, or a variation of the pattern, the chief of which is a fracture extending horizontally through the body, the pedicle, the transverse process and the spinous processes.

This pattern has been duplicated twenty-one times in this series. The lap seat belt modifies

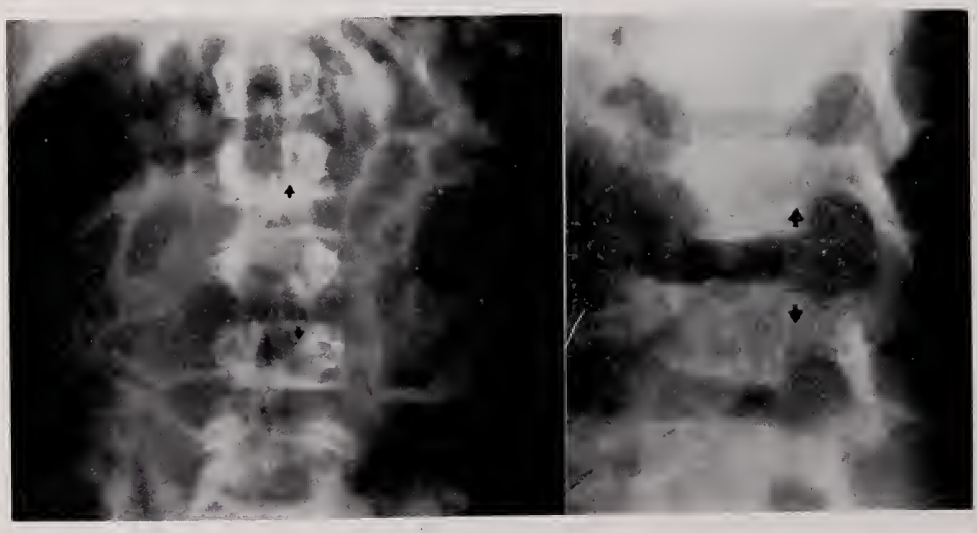


Fig. 2 (C & D).

Fig. 2C. Lumbar spine x-rays demonstrate the degree of distraction at L2-L3 and L3-L4 intervertebral spaces. This is well illustrated by the arrows adjacent to the distorted spinous processes.

Fig. 2D. The lateral view of the lumbar spine demonstrates the enlargement of the L2-L3 intervertebral foramen due to distraction of the joints.

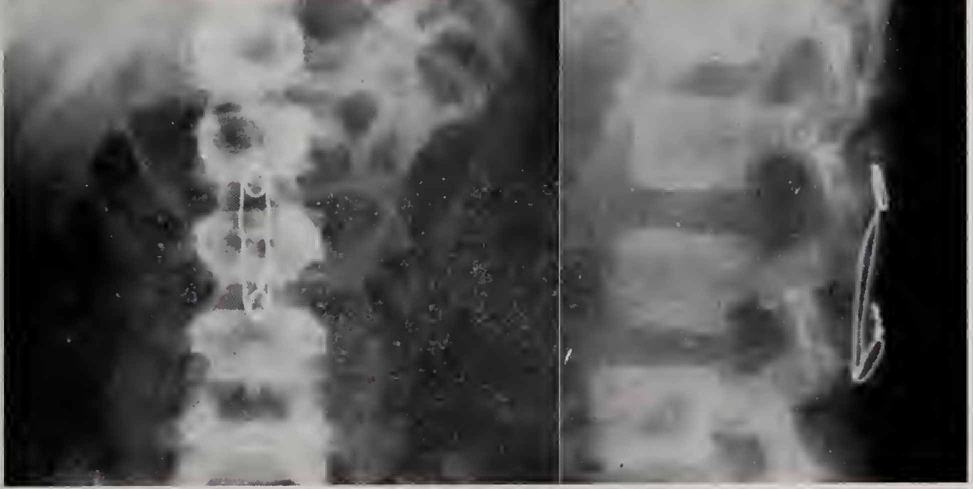


Fig. 2 (E & F).
These x-rays show the reapproximation of the L2 and L3 spinous processes and the stabilization of the lumbar spine by the wiring and spinal fusion which was performed.

the collision forces in such a way as to be a significant factor in the production of this unique lumbar spine injury.

Neither the skull fracture nor the distraction-fracture of the spine was associated with neurologic deficit. The abraded skin across the groin bilaterally is a typical lap seat belt contusion.[9] The child's initial abdominal signs were probably due to a combination of contused abdominal wall and a contused or perforated bowel. Although spinal cord injuries may be associated with a paralytic ileus, a fracture-dislocation at the L2-L3 interspace could not account for the rectus muscle spasm. A spinal cord injury at this level would manifest itself by neurologic signs in the lower extremities, and not in the trunk or abdomen. The signs which appeared two weeks after injury were due to intestinal obstruction. Alertness of the surgical intern in detecting these signs and the prompt surgical treatment allowed complete recovery from this injury. Surgeons should be aware that injuries severe enough to contuse the abdominal wall may also contuse intra-abdominal viscera. This may lead to delayed perforation, scarring, hemorrhage, or intramural hematoma formation in bowel. Other cases of lap seat belt injuries associated with ruptured viscera have been been reported.[5,9,22,41]

A comprehensive review of the various seat belt injuries has been presented by Snyder *et al.*[38]

Fractures of Roofs of Both Orbits And the Naso-orbital Region

Case 3: I.S., a small forty-one year old, right handed housewife, was occupying the front passenger seat in an automobile which was involved in a head-on collision on December 14, 1966 (Fig. 3A). The resulting damage was photographed by the anatomist (Huelke). The patient's husband, who did not have his seat belt fastened, struck the windshield (Fig. 3B) and sustained lacerations and bruises of his face and scalp. He was not rendered unconscious. His wife had her lap seat belt fastened but nevertheless struck her head on the edge of the instrument panel (Figs. 3C thru 3F). She did not lose consciousness. Upon examination her blood pressure was 170/100 and her pulse was 88 per minute. There was a bloody serous fluid exuding from both nostrils. She had a 4-centimeter laceration medial to the right eye, but her

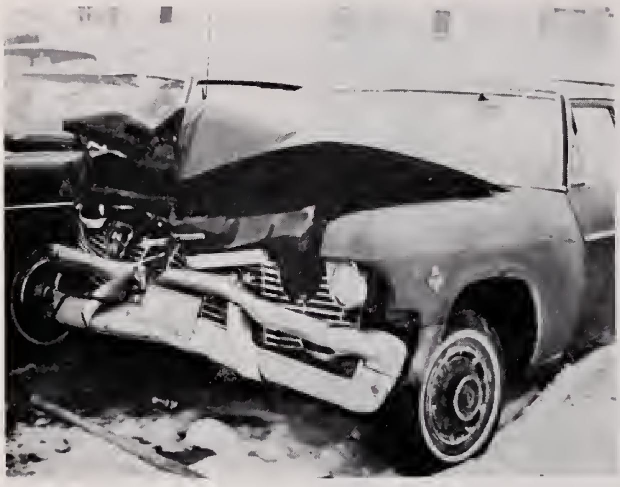


Fig. 3A.

The result of the head-on collision in which the patient was injured is shown.

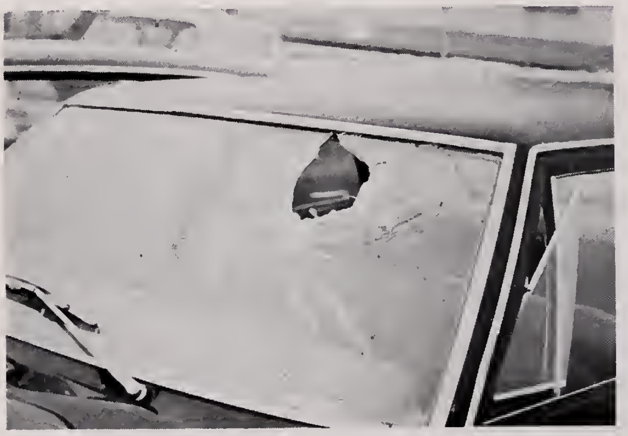


Fig. 3B.

The driver, who was not wearing a seat belt, struck the windshield with his head. The point of impact is at the center of the 'spider web' of shattered glass, while the point where he sustained his lacerations is about six inches below. This downward arcing of the head thus accounts for the slicing lacerations so commonly seen in accident victims striking the old type of windshield glass.[21] (Since 1966 American model cars have used a new improved windshield which markedly reduces the frequency and severity of facial lacerations).

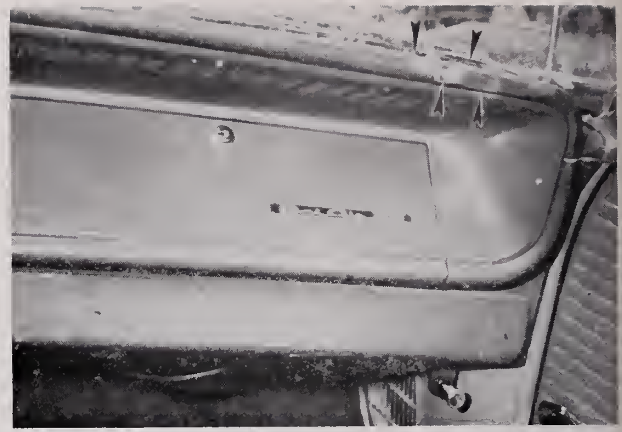


Fig 3C.

The patient, riding in the guest passenger seat and wearing a seat belt, was thrown forward so that his head struck the unpadded and unyielding instrument panel. Only smudge marks on the edge of the instrument panel indicated the point of impact.

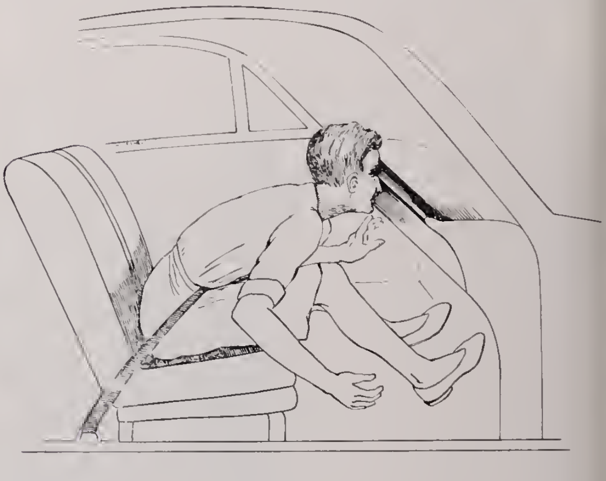


Fig. 3D.

The acute symmetrical blow of the head against the dashboard is shown with considerable hyperextension of the neck. Note the restraining action of the seat belt with the associated flexion of the lumbar spine. This type of pattern is especially true for small occupants. Taller individuals will strike the top of the instrument panel.

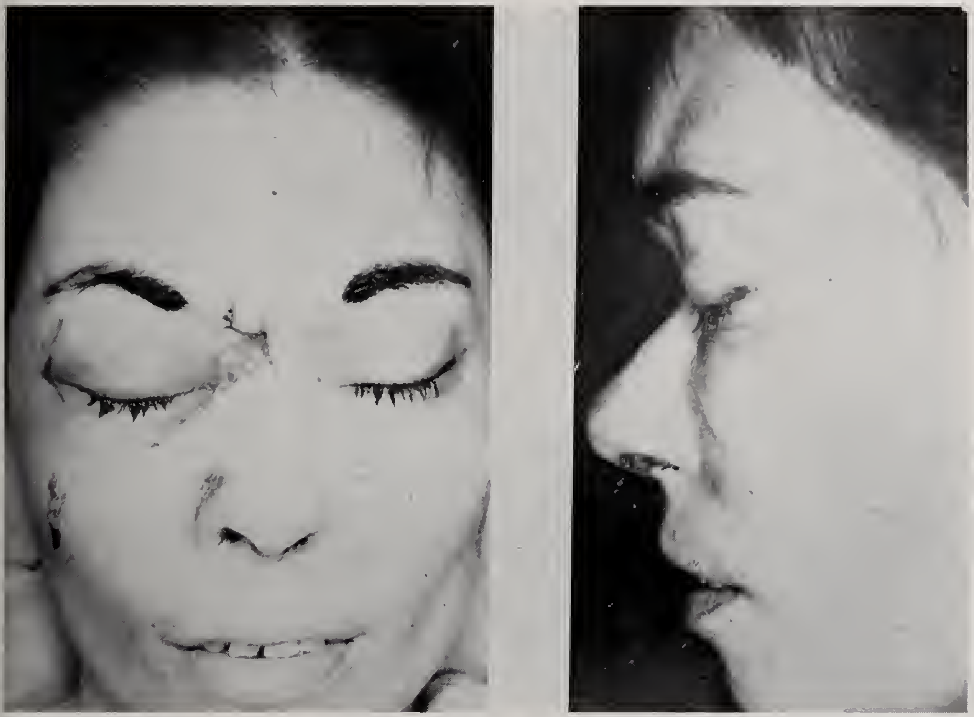


Fig. 3 (E & F).

The anterior and lateral view exhibit the compound fracture of the nose and marked inward displacement of the nasal bone.

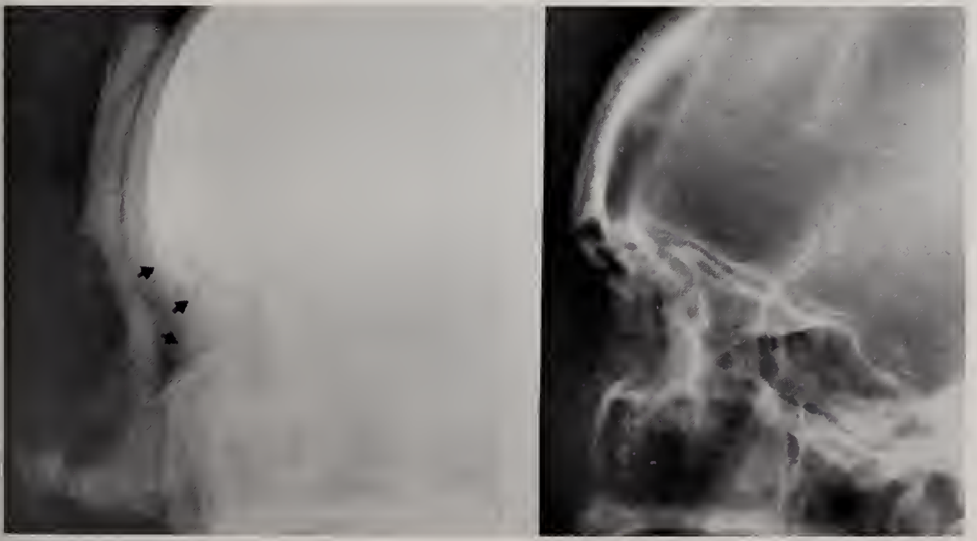


Fig. 3 (G & H).

Fig. 3G: The lateral view of the nose shows the comminuted depression of the nasal bone. The paper-thin bones (lacrimal bone and lamina papyracea of ethmoid bone) which make up the medial wall of the orbit have also been fractured and displaced backward.

Fig. 3H: The fracture of the cribriform plate is demonstrated anteriorly.

pupils were equal and reacted to light. A subconjunctival hemorrhage was noted in the right eye and the extraocular movements impaired in all directions; the right pupil was 2 millimeters larger than the left. The remainder of her neurologic examination was normal.

Skull x-rays showed pneumocephalus and demonstrated the depressed comminuted compound fracture at the nasion (Fig. 3G) with fractures of the roof of both orbits as well as fractures of the right zygoma, nasal bones, and medial walls of both orbits (Fig. 3H).

A transcoronal incision was made and a bifrontal craniotomy based on a right temporal muscle flap was performed by the neurosurgeon (Schneider). The inner table of the frontal region had been avulsed from the outer table bilaterally as a solid piece (en bloc) carrying with it

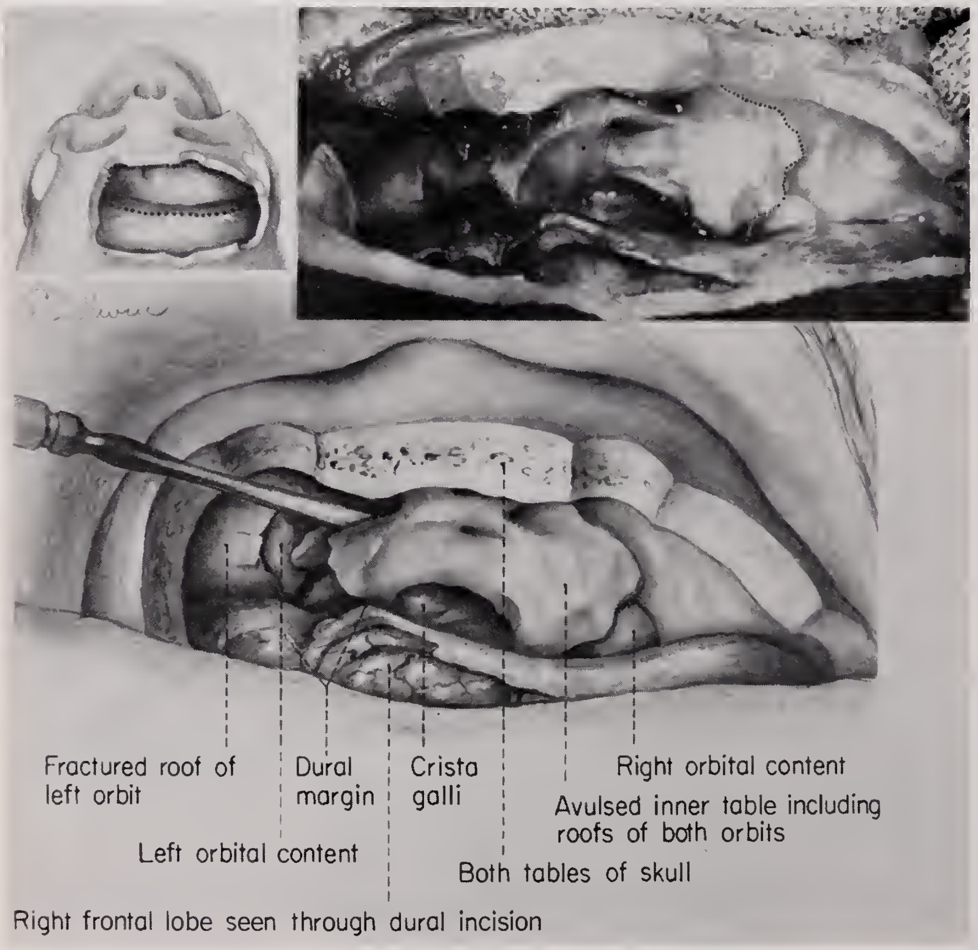

Fractured roof of left orbit
Dural margin
Crista galli
Right orbital content
Avulsed inner table including roofs of both orbits
Left orbital content
Both tables of skull
Right frontal lobe seen through dural incision

Fig. 3I.

Insert top, left: Site of craniotomy exposure.

Insert top, right: Actual photograph of site of "en bloc" avulsion of inner table of frontal bone bilaterally including cribriform plate, crista galli and the roof of both orbits (dotted line).

Lower diagram: This drawing identifies the structures at the site of the lesion seen in the photograph above.

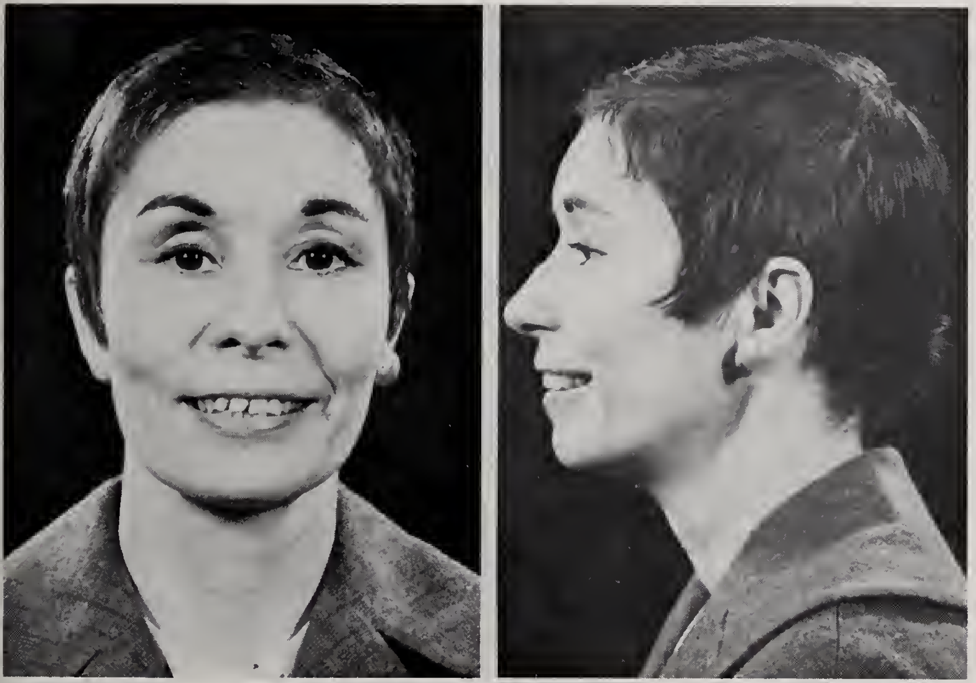


Fig. 3 (J & K)

The patient is seen five months postoperatively with the nasal bones in their normal position.

the crista galli and the anterior portions of the roofs of the orbit bilaterally (Fig. 3I). The inner and outer bone tables were wired together. The posterior orbital roof was completely morcellated bilaterally and had to be excised piecemeal. Four lacerations in the dura could be readily closed by simple suture. When these suture lines were tested by the injection of indigo carmine intradurally, the dura was watertight. The plastic surgeon (Grabb) then repaired the facial lacerations and performed an open reduction and internal wire fixation of the nasal fractures. The patient received triple antibiotic therapy and made an uneventful recovery. She was discharged on December 30, 1966, with slight diplopia on left lateral gaze.

Five months postoperatively at a return visit she was mentally alert, asymptomatic, and had obtained a good cosmetic result (Figs. 3J and 3K).

Comment: In this accident the driver was not wearing his lap seat belt and was thrown forward over the steering wheel striking the windshield with his face. The lacerations which he sustained were typical of those occurring by downward head movement with the face passing through the glass as has been described by Huelke, Grabb, and Dingman.[21] The point of impact in this accident was head-on, more in line with the front guest passenger; the driver was somewhat protected by the steering wheel.

In the case of his wife, who was in line with the impact, the seat belt undoubtedly saved her life but nevertheless she struck her head on the unpadded and unyielding instrument panel. Externally the most striking feature of her injury was a markedly depressed naso-orbital fracture, the extent of which was confirmed by the x-ray examination. She also had bilateral bloody cerebrospinal fluid rhinorrhea indicating communication with the subarachnoid space. If such drainage is permitted to continue untreated surgically, the result may well be future chronic bouts of meningitis, or brain abscess and subsequent death.[31]

> *In this case the skull fracture was unique in that the entire inner table of the skull, including the crista galli and the roof of both orbits was avulsed completely and almost symmetrically, en bloc, as a single huge fragment of bone.*

Although there were multiple bony fragments at the posterior portion of the orbits, fortunately there was no damage to the orbital contents. This has not been the usual experience of the neurosurgeon who has repaired approximately 75 such post-traumatic frontal cerebrospinal fluid fistulae. The orbit is often injured, the optic nerve may be avulsed, and usually the cribriform plate buckles in such fractures with several bony spicules lacerating the dura and occasionally penetrating and becoming imbedded in the brain.[30] Such dural lacerations are frequently associated with large dural defects and usually require a dural graft. In the case here reported there were only four linear dural lacerations without any loss of this tissue so watertight closure could be obtained by simple interrupted black silk sutures. The lack of avulsion of the dura can be accounted for by the massive single bony fracture. Such an en bloc fracture of the skull probably requires a direct symmetrically applied blow to the base of the nose. This case supports two old neurosurgical adages:

1. There is always 100 per cent more damage to the skull visualized intracranially at operation than is seen in the preoperative skull x-ray of the patient with this type of fracture.
2. Some of the worst skull fractures often are associated with little or no brain damage, for there is a dissipation of force instead of the direct force transmission to the brain.

Dingman, *et al*[7] have urged the early reduction and fixation of this type of nasal fracture to prevent chronic facial deformity or disfiguration. The excellent cosmetic result attained in this patient supports this dictum and demands that it receive further active support.

Facial Laceration And Back Strain

Prevention of severe facial and intracranial injuries from head impact can be accomplished by adequate instrument panel design in the head impact areas. This is illustrated in the following case:

Case 4: Two women, both short of stature, were driving with the front seat moved well forward. Both were wearing the lap seat belts. The car was forced off the road; it struck a tree at 20-25 m.p.h. The impact was to the center front of the car. The passenger flexed over her belt and struck the unpadded instrument panel with her face (Fig. 4). Besides bilateral periorbital ecchymosis, she had a hairline fracture of her left maxilla. An "L" shaped laceration between her eyebrows was sustained when she struck the corner of the radio grille which did not deform with the instrument panel. Her main complaint was a sore back. She had stretched the vertical deep back muscle group from the coccyx to the upper lumbar area. At the time of the accident her seat belt was worn high,

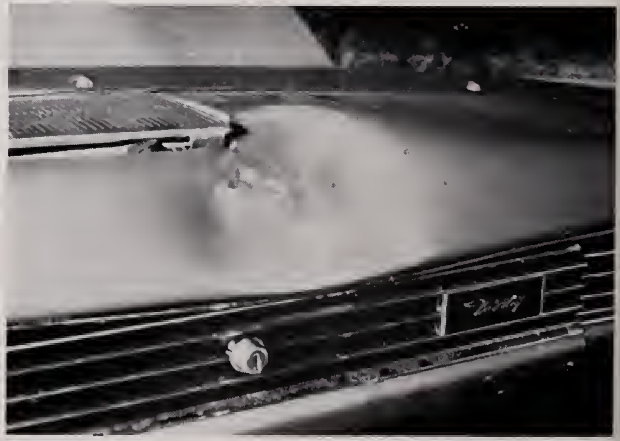


Fig. 4

Facial impact of a seat belted passenger onto an unpadded instrument panel. The occupant sustained a hairline fracture of the left maxilla, an "L" shaped laceration between the eyebrows from the edge of the radio grille. Stretching of the deep back muscles in the lumbar area was the main complaint of the patient.

above the iliac crests, and she had on a "substantial" foundation garment. Several weeks later her back problem resolved itself without clinical treatment.

Comment: In this case the instrument panel deformed, dissipating the impact energy. It is this type of instrument panel response to head impact that is required for the seat belted occupant. Padding over this deformable metal panel would have spread the impact load over a wider area and possibly prevented most of her facial injuries. The seat belt not being worn properly and the possible restraining effect of her foundation garment prevented adequate flexion over the belt, causing severe strain of the deep back muscles.

Brachial Plexus Involvement

Case 5: A young driver, who had lost his license due to numerous driving violations, lost control of the car on a curve, crossed the center line, and struck another car. Both vehicles struck right front to right front. The driver at fault was not wearing a seat belt. He struck his head on the right side of the instrument panel and died of intracranial injuries.

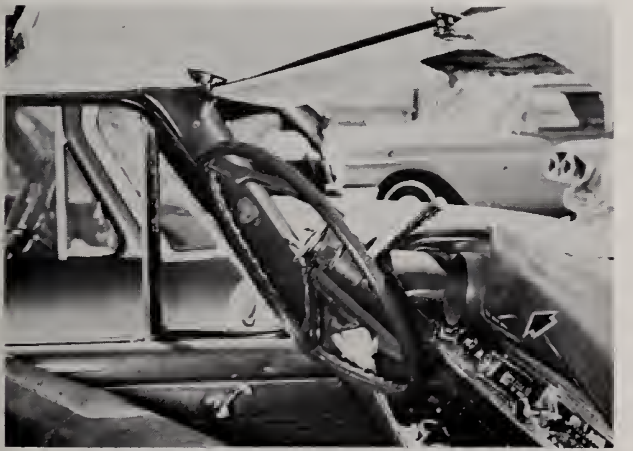


Fig. 5
Collapse of the steering wheel by a seat belted 230 pound male driver. Minor facial lacerations and a sore chest were sustained from wheel impact. His right shoulder struck the instrument panel producing a stretching of the brachial plexus roots and partial loss of shoulder joint function for six months.

The sixty-two year old 230 pound male driver of the other car was wearing a lap seat belt. He flexed over the seat belt and collapsed the steering wheel sustaining a sore chest and facial lacerations (Fig. 5). His right shoulder had struck the instrument panel and he had suffered marked paresis of the right deltoid, supraspinatus and infraspinatus muscles with slight weakness of the right triceps and biceps muscles and a minimal hypesthesia over the C4 dermatome. There were compression fractures of the T9 and T10 vertebrae with paravertebral hemorrhage, a fracture of the right acetabulum, the right inferior ramus of the pelvis, a fracture of the radial head of the right elbow, a trimalleolar fracture of the right ankle, fractures of the left zygoma and the right maxillary sinus.

The patient was in traumatic shock at the time of admission to the hospital. After this had been treated a general surgeon sutured the facial lacerations including a transected parotid duct. The trimalleolar fracture was reduced and stabilized by internal fixation and the fracture of the right elbow placed in a cast by the orthopedic surgeon. The neurosurgical consultant reviewed the symptoms referable to the right upper extremity and made a diagnosis of brachial plexus stretch injury which was treated by support and physiotherapy. The patient's course was one of continued improvement with discharge from the hospital six weeks after the injury.

Comment: In this severe accident the unbelted driver of the one car moved out of his position behind the wheel to sustain fatal injuries when he struck his head on the right side of the instrument panel. On the other hand the belted elderly driver of the second vehicle survived although he had multiple injuries which were rather successfully treated by a team of surgeons. In this case the lap seat belt no doubt saved the patient's life.

DISCUSSION

The multidisciplined approach to the care of highway injuries not only provides a better treatment for the patient but reveals some interesting lesions possibly related to the use of lap seat belts: the hangman's fracture (Case 1), the distraction fracture of the lumbar spine (Case 2), injury to the abdominal viscera (Case 2), and the "en bloc" fracture of the inner table of the skull and naso-orbital region (Case 3).

DeHaven, *et al*[6] have pointed out that injuries which seem directly related to the lap seat belt "are actually determined by other factors such as a failure of safety belt installations and vertical acting crash forces." Garrett and Braunstein[14] studied the "seat belt syndrome" in 3,637 occupants of 2,778 accident-involved automobiles and found 150 of these people had received an injury to the lower torso. Of these, twenty-six injuries were regarded as serious, consisting of intra-abdominal injuries (7), pelvic fractures (7), and lumbar spine fractures (12); but the majority of these people were in very severe accidents. These authors were able to find only a single case of a fatal lower torso injury in this group, thus demonstrating the effectiveness of the lap seat belts. Greater lap belt snugness by inertia reels[28] might have afforded increased protection in Case 2.

THE LIMITATIONS OF seat belts have also been recognized.[25] The single upper torso restraint is highly undesirable, for without an accompanying lap seat belt the passenger slides out underneath such a harness (submarines) and is liable to added injury such as fractures or dislocations of the cervical or thoracic spine.[12,15] When the three point system is used in which the diagonal strap is joined to the lap belt, there is a tendency for the lap belt to be pulled upwards onto the soft abdominal wall. It has been recommended that the lap and shoulder belt be separate (Fig. 6), for this combination does not have the undesirable characteristics of the other systems mentioned above. Such a double, independent belt system will still offer lap belt protection for those who for some reason will not wear the shoulder belt. A lap-shoulder belt combination (Fig. 6) would very likely have offered sufficient upper torso restraint in all cases so that it is doubtful whether the chin would have been caught upon the steering wheel (Case 1) or the head impacted against the dashboard as occurred in the other cases. The importance of available "cabin space" has been emphasized by Huelke and Gikas; for when there is collapse and compromise of the cabin area, the value of any restraint system is negated.[20] There is a definite need for an adequate child restraint system.

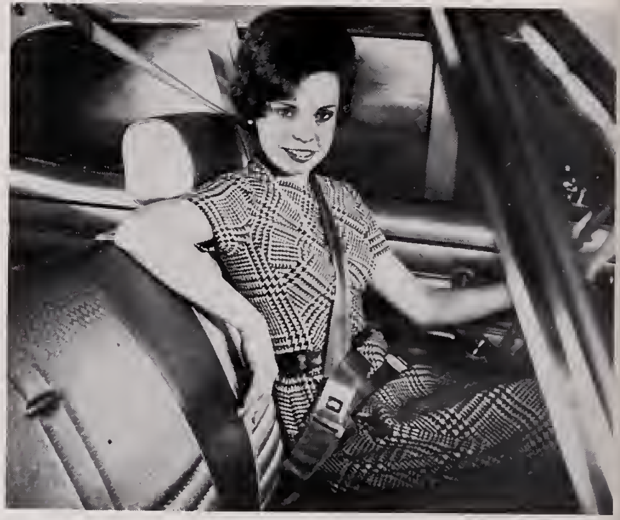


Fig. 6

Lap-shoulder belt combination. Note individual buckles for the lap and for the shoulder belts.

It is possible that restraining the pelvis and upper torso by the use of the lap and shoulder belts may occasionally permit the cervical spine to be snapped at the time of forward impact in rear end collisions. Hyperextension of the cervical spine can be prevented by the use of a head support. It is possible that if such a head restraint is not adequately designed, the head and neck could sustain a severe blow as they swing back and strike the head support. Since there is a certain degree of inertia of the intracranial contents, the brain could rebound forcibly forward striking the frontotemporal junction against the sharp margins of the sphenoid ridges with possible cerebral contusions or lacerations to the frontotemporal junction resulting in an intracerebral clot.

Recently a car was struck in the rear and pushed through a bridge railing. It fell 100 feet to the ground into the yard of a foundry at an estimated speed of 53 m.p.h. The car landed on its rear end. The driver, a thirty-four year old, 270-pound male, was not wearing seat belts but did have a head support. He claimed he held tightly to the steering wheel during the fall and probably had his head on the head support. He was not unconscious and did not complain of any neck pain. His only injury was a fracture of the right humerus.[29] Time and careful clinical examinations will provide the answer as to whether such a specific safety feature could possibly cause serious injuries when the head is not in direct contact with the head support.

SUMMARY

Case histories of five automobile accident survivors have been presented in detail. Each of these individuals wore a lap seat belt the use of which in most cases probably saved the occupant's life.

Emphasis has been placed on the treatment of these patients by a coordinated multidisciplined team which helped them recover, but in so doing the team also noted new types of injuries related to the lap seat belt restraint.

The findings of this study suggest that although the patients' lives were saved, the further advance of lap and shoulder belts might have provided additional protection and completely prevented any serious injury.

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Geographic Pathology

Editorial Comment: The information contained in this interesting presentation may seem unrelated to the practice of medicine in Michigan. Nevertheless, the subject is interestingly presented, and as made abundantly clear by the author, such terms as "tropical disease" are no longer geographically oriented. We also are given a clearer insight into some of the medical problems that our advisers face in distant lands.

— George Lowrey, M.D., Scientific Editor

BY JOHN T. HEADINGTON, M.D.
ANN ARBOR

Introduction

Geographic Pathology attempts to describe disease within certain geographic areas, to seek causes of disease, and to find reasons for distributional differences. In the past, Geographic Pathology has been defined as part of a much larger body of Geographic Medicine in which Pathology supplements and complements Geographic Physiology, Biochemistry, Microbiology, and other sciences. Avtsyn[1] expanding the temporal dimension adds that Geographic Pathology "includes not only diseases in their initial stages, but also premorbid conditions, i.e., distribution of homeostasis which sooner or later provoke disease."

For the definition to be complete, however, there must be included consideration of those conditions which disturb the normalcy of the human external environment, notably, war, industrialization, urbanization, cultivation, and pollution. These are of equal or greater significance to the total community than the random disturbances or internal environment to which they may be ultimately related.

Political, religious, social, and cultural institutions, therefore, may affect geographic differences in disease as significantly as do temperature, altitude, and humidity. Consequently, instead of remaining restricted by a disciplinal perspective which has been limited to the physical and biological sciences, Geographic Medicine and Geographic Pathology must now also take full measure of the useful contributions of the social sciences: Political Science, Economics, Sociology, Psychology, and Anthropology. One needs only to ask what cultural and social bias determines the effective utilization of health services in any geographic area in order to appreciate that complete understanding of the community is important not only for determination of patterns of disease but also for delivery of health care.

The Geographic Pathologist, as a contributor to Geographic Medicine, is but one member of a diverse team whose combined effort seeks the whole truth.

North Thailand: Geography, People, and Climate

North Thailand is a region of densely jungled parallel mountain ridges verging numerous streams and rivers which wind southward eventually to empty into the Gulf of Siam. These turbid waters interconnect a series of level-flooded basins of varying width and length. Thai-speaking peoples for many years have farmed the rich argricultural lands of the major intermontane basins, and although Northern Thais have some linguistic differences from others in central and peninsular Thailand, they are closely related by similar religious, economic, governmental, and social institutions. At the present time, even regional differences are in transition toward greater uniformity as communication, education, and transportation continue to improve.

In contrast to the relatively narrow river valleys, the wide-ranging and rugged mountainous areas are sparsely populated. Some 20 different tribal peoples in these mountains, numbering upwards of 200,000, from three main ethnic groups: Tibeto-Burmese, Wa, and Yao-Meo-Pateng.[2] Until very recently, these hill tribes of North Thailand were almost entirely isolated from the mainstream of Thai culture and institutions. They had been largely left to themselves, free to pursue their slash and burn agriculture with high-grade opium as the most important cash crop. Until recently, perennial lack of official concern for the northern and northeastern hill tribes has been in some

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Doctor Headington is an assistant professor of Pathology, the University of Michigan, Ann Arbor, Michigan, presently on leave to Chiengmai University School of Medicine, Thailand.

ways reminiscent of deficiencies of French colonial policy in Indochina which were so successfully exploited by Ho Chi Minh shortly after the 1954 cease-fire.[3]

Ho's success in obtaining the support of the large number of ethnic minorities of North Vietnam (estimated 2,500,000 in North Vietnam compared with Thailand's estimated 200,000), has not been overlooked by Communists responsible for indoctrinating tribal peoples in Thailand and in Burma. It has therefore become both emergent and expedient to gain the support and allegiance of the Thai border-dwelling hill tribes. Accordingly, border police and ARD (Accelerated Rural Development) teams are providing some simple health services and instruction in sanitation practices as examples of the government's concern.

Unfortunately, the results of years of neglect do not disappear overnight with the declaration of good intentions, and there is reason to believe that the current crash programs are already 5 to 10 years behind if not in some instances altogether too late.* A liberal lashing of instant medical care may only exacerbate the situation if a continous and long-term program of health services is not provided.

The natural north-south distribution of the river valleys has been responsible for the north-south projection of most important highways and railroads. Good all-weather east-west roads in the north are mostly lacking altogether or are still under construction. The absence of these cross-connections and small feeder roads has been one of the most serious obstacles in overcoming the prolonged isolation of mountainous communities.

The preservation of considerable genetic homogeniety within the hill tribes as well as in many of the remote Thai-speaking villages has been an important biologic consequence of the many years of rural isolation. These groups now provide population geneticists with some extraordinarily fertile opportunities for determining the incidence of a number of genetic markers such as blood groups, haptoglobins, and abnormal hemoglobins. With the extension of genetic studies, it is anticipated that there will be substantial changes in theories of ethnogenesis of tribal groups throughout mainland Southeast Asia.

The climate of North Thailand is moderate and generally pleasant the year around, although it is considerably more variable than that of the central plateau or the peninsular coast. Seasonal monsoon winds are the most important influence on weather; local geography may cause differences in rainfall and temperature within a more general pattern. Four seasons can be defined meteorologically, but they tend to merge indistinctly and variably without the abrupt seasonal changes which are typical of northern temperate zones.

During November to February, winter comes when the wind shifts to the northeast and masses of cold air begin to surge south from China. This cold dry air gradually results in termination of the rainy season. The hot summer begins in late February or early March when the daily maximum temperature may climb into the nineties or higher. Humidity falls. Mountain streams dry and rivers shrink. Vegetation sears and many trees lose their leaves in a curious reversal of foliage patterns in contrast to the temperate zone spring. When the fields and forests dry, thousands of fires burning night and day in the paddy fields and mountains fill the air with smoke and fine ash to produce an atmospheric haze which extends upward for thousands of feet as a blanket over the whole of north and central Thailand.

In May or early June warm moist air from the Indian Ocean begins to flow over the hot land as winds shift to the southwest and then rain begins to fall to clear the air and freshen the landscape. The first anticipatory rains are known as mango showers and are prized by orchardists for the salutary effect on the mango and lumyai crops. Rains gradually increase in frequency and intensity until sometime in September when rivers begin to crest in the far north. If flooding occurs, as it frequently does in October and November, there is always the threat of typhoid and cholera. But like the annual beneficence of the Nile, the summer monsoons provide the abundant water and repeated flooding which is required for growing paddy rice, the sustenance of the villager and the most important export of Thailand's agricultural economy.

A period of transition between the end of the Southwest monsoons and the beginning of winter occurs with a shift to the northeast monsoons and extends through October and November with moderating temperatures. This is the time of the rice harvest and numerous festivals.

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*Bangkok Post, July 26, 1967

In spite of the lack of extremes, the changes in seasonal living habits significantly affect the patterns of health and disease. In the north during the winter when nocturnal temperatures may reach 5-10°C., many children are seriously burned when clothing, bedding, and mosquito netting are accidently ignited by open fires or spilled kerosene lanterns. As the rainy season develops, mosquito-borne diseases increase, particularly dengue, hemorrhagic fever, and viral encephalitis. The rainy season is also the time for exacerbation of malnutrition as protein foods are depleted and supplies of fruit and vegetables are at a low ebb.

A careful study of enteric infections in Chiengmai,[4] the largest city in North Thailand, showed that food poisoning and dysentery were most frequently seen in the interval from May to September. Amoebic dysentery was most common during the late hot dry season of April, May, and early June. It was concluded that the incidence of enteric diseases showed some correlation with the rising mean temperature and the developing rainy season, and that this appeared to be less associated with decreased water sources than with increased intake and carelessness in selection of liquids. It was also found that rain-diluted water tended to enhance the survival of enteropathogens. The monsoon rains, therefore, contribute to the seasonal incidence of these infections.

Not only is variation in rainfall an important factor in the epidemiology of some infectious diseases, but it is also of critical importance to rural people who do not live near all-weather roads. During the rainy season many remote areas in north Thailand are completely isolated except by air or foot travel. At this time of year, acute medical and surgical problems in remote villages remain untreated. The hardship of this seasonal isolation is emphasized by the observation that when it is at all possible some rural patients will overcome great difficulties to reach the modern facilities of the Chiengmai University Medical Center: A woman with a 10 kilogram ovarian neoplasm walked over jungle trails for three days to reach the nearest road in order to ride by public bus for another 18 hours; a man with acute peritonitis due to perforation of the small intestine from primary lymphosarcoma was carried several kilometers by bullock cart from his isolated village to a road where he was placed on a bus for a six hour trip to the hospital. The impact of a new medical institution on rural health care in a developing country can practically extend only as far as the rural roadhead. Whether or not it reaches that far is a responsibility of the institution and is dependent on the available resources.

Some Diseases of Special Interest

Tropical medicine has come to be a Geographic misnomer, a restricted and anachronistic term, having its origin in the days when a medical visit to the tropics by a European meant tse tse and elephantiasis, cholera and guinea worm. Stanley and Livingstone. It has been characteristic for schools of tropical medicine in the temperate zones to mostly emphasize parasites and microbes found between Cancer and Capricorn. Tropical countries might just as well set up schools of "temperate medicine" to selectively teach diseases uncommon in the torrid zone. A recent *omnium gatherum* of tropical medicine[5] devotes all but 36 of its 931 recently revised pages to infectious, parasitic, and arthropodal diseases. The fault is a matter of bias and emphasis which tends to restrict a proper view of the whole: genetic defects, neoplasms, degenerative diseases, and many other conditions are equally important as infectious disease and may be as geographically specific.

Tropical diseases of special interest are, therefore, usually special to the visitor, but are not necessarily special to the local practitioner who may be all too familiar with them. Nevertheless, some of the following are of unusual interest even as measured by the parochial eye.

CHILDHOOD MALNUTRITION: Severe Protein-calorie malnutrition was not considered a significant problem in Thailand until quite recently. The first cases were reported from South Thailand in 1955.[6] In 1966, Thanangkul and Witaker[7] reviewed more than one hundred northern Thai children with varying degrees of protein calorie malnutrition admitted to the pediatric wards of Chiengmai University Hospital during 1964. They firmly established childhood malnutrition as an important disease in this area.

Childhood malnutrition is becoming a disease more and more characteristic of the demographic crisis as birth rates remain high and infant mortality decreases. Kwashiorkor and other clinical forms of severe malnutrition have been aptly called the disease of the displaced child — the infant who is displaced from the breast because of the necessity to feed the next born. Childhood malnutrition may also be a disease which follows cultural disintegration: for many years in certain parts of Africa, polygamy was a very effective form of birth control because it was a cultural taboo for a wife in a polygamous family to conceive within two years of the birth of her last child. This practice effectively spaced children at least two years and nine months apart and thus permitted a long interval of breast feeding.

The majority of Thai children with severe malnutrition are between one and two years. After removal from the breast they are placed on a weanling diet usually deficient in both protein and calories, which if prolonged results in severe retardation of mental and physical growth with wasting and apathy. There is probably also decreased immunoresponsiveness to infectious disease, and the common heavy infestation of intestinal parasites often exacerbates the underlying condition. Death from intercurrent infection is the rule. Prevention and treatment are the combined problems of population control and nutritional education.

THYROID DISEASE: North Thailand is an area in Southeast Asia in which iodine deficiency goiter is endemic. A recent study of surgical diseases of the thyroid in north Thailand,[8] before widespread iodine prophylaxis, revealed some striking similarities when data were compared with those from Michigan during the pre-iodine era.[9] This study confirmed a low incidence of lymphoid infiltrates in thyroid glands from a geographic area deficient in dietary iodine, a low incidence of lymphocytic thyroiditis, and total absence of Hashimoto's thyroiditis. Compared with a population in Michigan before iodine prophylaxis, there was a much higher incidence of adenoma and a much lower incidence of diffuse glandular hyperplasia. It was of considerable interest that the incidence of carcinoma of the thyroid in northern Thais was almost four times than that observed during the preiodine prophylaxis era in Michigan 40 years before. This suggested the possibility of a world-wide increase in thyroid carcinoma in recent years.

GENITAL TRACT CANCER: The incidence of most neoplasms of the male and female genital tract in north Thailand is approximately the same as for other areas of Southeast Asia.[10] In general, compared to the United States, there is a high incidence of squamous carcinoma of the penis and uterine cervix with low incidence of adenocarcinoma of the prostate and body of the uterus. In Thailand, as in other parts of Southeast Asia, there is also a strikingly high incidence of trophoblastic tumors. According to Novak,[11] the incidence of molar pregnancy in the United States is about 1:2500; in Chiengmai Province of north Thailand the incidence is about 1:300.[12] A provocative study from the Philippines where there is a similarly high incidence has suggested that disturbances of trophoblastic tissues may in some way be related to deficiencies of human nutrition.[13] Thus far, however, there is little more than statistical and empirical evidence to support this interesting postulate.

EOSINOPHILIC MENINGOENCEPHALITIS: A severe and potentially fatal parasitic infestation of the central nervous system may follow accidental ingestion of infective larvae of a metastrongylid rat lung worm, *Angiotrongylus cantonensis.* Recently detected in large numbers in Thailand,[14] the parasite has been reported since 1957 as causing eosinophilic meningoencephalitis in man in Australia, China, Formosa, Guam, Hawaii, Ponape, New Caledonia, Saipan, and Tahiti.[15] Although suitable intermediate hosts are probably widely distributed, the human incidence is low because of the requirement for ingestion of a planarium or raw mollusk, usually a snail or slug. Cerebral symptoms may be quite variable and even suggest the possibility of psychosis or a space occupying lesion. The finding of numerous eosinophils in pleocytic spinal fluid from a potentially exposed patient indicates the possibility of angiostrongylus infection. Similar findings have been described in cases of cerebral infection with *Gnathostoma spinigerum.*[16, 17]

BARTONELLA-LIKE ACUTE FEBRILE ANEMIA: In 1966, Whitaker[18] described an acute febrile anemia associated with Bartonella-like erythrocytic structures. Bartonellosis, until the time of this communication, had been remarkable for its greatly restricted distribution in western South America. Three previously well Thai males were described as having continuous fever, malaise, hepatomegaly and pallor with a severe and rapidly progressive hemolytic anemia. Erythrocytic structures similar to Bartonella organisms were found. Although the relationship of this hemolytic syndrome to Bartonella species has not yet been established beyond doubt, similarities to

Oroyo fever are striking and at least one additional patient has been seen with similar findings since publication of the first report.

SEGMENTAL GANGRENE OF THE SMALL INTESTINE AND MESENTERIC ADENITIS IN CHILDREN: Early in 1967 there appeared a report of segmental gangrenous infarcts and mesenteric adenitis in Northern Thai children.[19] The typical clinical features in young children were: abrupt onset of low fever, diffuse abdominal pain, vomiting, a severe watery diarrhea with feces strongly positive for occult blood, then onset of paralytic ileus followed by peripheral vascular collapse. After review of a necropsy in clinico-pathologic conference the correct diagnosis was subsequently made in three additional children who survived following segmental resections of the small intestine. Although there are some features of this condition in common with "pig bel" enteritis as reported by Murrell[20] from the highlands of New Guinea, we have so far been unable to recover a Clostridium species from a small number of more recent cases. A seasonal distribution now seems likely as no new cases were observed until onset of the rainy season. The etiology remains obscure.

GASTROINTESTINAL ANTHRAX: Cutaneous and pulmonary anthrax, the most common forms in the United States, have usually appeared as occupational diseases in workers processing hides and animal hair imported from endemic areas. Gastronintestinal anthrax is almost always a result of eating improperly cooked meat from an infected animal. After ingestion of the live organism there develops a severe acute phlegmonous inflammation of the bowel, usually the terminal ileum and colon. This enteric form of anthrax is occasionally seen in north Thailand in the form of small epidemics as several individuals share the meat of an infected water buffalo or bullock. Good data are not available, but the general impression is that case mortality is very high, even in the face of massive antibiotic treatment.

PHYSICAL TRAUMA: In any rural area various forms of physical trauma have always been a significant contribution to disease. In north Thailand, traumatic events sometimes occur on a large and dramatic scale, such as a recent opium war in which, "300 former Kuomintang irregulars were killed . . . in a bitter battle between two armed Yunnanese bands over opium smuggling profits in the area where the borders of Thailand, Burma and Laos meet."*

Villagers are still occasionally mauled by hungry tigers and hunters gored by angry elephants. But times are changing, the jungle is receding, and the placid pace of the Thai water buffalo is giving way to the staccato dash of the Japanese motorcycle. What the Model T Ford was to the rural United States 40 years ago, the Honda is to rural north Thailand in the 1960's. The incidence of death and injury due to motorcycle accidents is a serious problem as traffic laws are something for a more conservative future and hundreds of "learners" having their first real taste of the machine age careen wildly along in great good humor. Forensic Pathology has its special geographic emphasis as well.

Geographic Pathology and Medical Education

Determination of geographic differences in disease is necessary for planning and revision of the mode and content of a medical school curriculum, for directing the emphasis of medical research toward the reality of urgent and remediable human problems, and for proper orientation of service facilities to specific needs within existing economic limitations. Appreciation for such differences when planning a new medical school in a developing country in which resources are limited can help direct the new institution to a truly realistic and useful relationship to the community which it is to serve. The question of relevancy of institutions, both functional and economic is particularly pertinent to the underdeveloped areas of the world. A medical school which abstains either by default or design from direct involvement with community health needs becomes an academic luxury few developing nations can afford. This view by no means excludes a tolerable concern for molecular biology, but there is a definite requirement for proper emphasis and priority.

The importance of geographic differences in disease to medical education was indirectly illuminated by Ledley[21] writing about computer aids to medical diagnosis. He pointed out that diagnostic probability depends on consideration of two factors (a population factor and a pathophysiologic factor): "The first is the probability that a patient being seen by a physician has (a certain) disease before his symptoms are observed." This population factor includes such important variables as geographic location, genetic factors, seasonal changes, epidemicity, endemicity, as well as cultural and socioeconomic differences.

By illustration, a properly oriented medical student in north Thailand, in contrast to his equivalently trained counterpart in the midwestern United States, knows without seeing the patient that bloody diarrhea is more likely to follow amoebic rather than ulcerative colitis; that the cause of hydrops fetalis is more likely due to the presence of Bart hemoglobin than RH isoimmunization; and that peripheral neuropathy is probably a result of B vitamin deficiency rather than a complication of diabetes mellitus. Some of these population factors, particularly information about infectious disease, are continuously changing, and this highly dynamic state requires an open-ended curriculum in which today's necessary information is replaced by; not supplemented by, tomorrow's.

The pathophysiologic factor is the second upon which diagnostic probability depends. This factor, independent of the constantly changing geographic variables, presumes that observed signs and symptoms are the result of more or less specific and unchanging structural and physiologic phenomena: aortic valvular stenosis has potentially similar pathophysiologic consequences whether it is developmental or postrheumatic; the molecular basis for a hemoglobinopathy is unaltered by its detection in an Asian or European.

The sum of these two general factors, population and pathophysiologic, can be used to determine the content of the curriculum. Special consideration of these factors, therefore, makes it possible for a medical school to be unique if it is decided that the institution shall be relevant to a specific community, whether local, regional, or national.

A knowledge of geographic differences in disease can also be useful in determining the mode of the curriculum, because the teaching methods should be directed to the real problems facing the new graduate. For example, there should probably be a considerable difference in curricular mode if the average graduate is expected to be the only medical authority totally responsible for the health care of thirty or forty thousand illiterate and superstitious villagers in the rural isolation of some developing country as compared with the average graduate who anticipates a highly restricted private practice of some medical specialty in an urban area of the United States. Administrative skills and economic perspectivies of an entirely different magnitude are required of the graduate of the developing country. He may have to learn how to establish priorities for services in order to do the most good for a selected portion of the population within severe economic limitations and without much regard for the traditional physician-patient relationship.

If there is a physician-population ratio of 1:20,000, it is clearly pointless with respect to the community as a whole, if the only physician available restricts his practice of medicine to those patients he can treat personally, all good intentions and 18 hour days not withstanding.

In addition, although there is much to be known, the curricular mode must also take advantage of teaching methods which bear upon how students learn. It is predictable that medical students in different parts of the world subject to important cultural and social differences will not respond uniformly to any single teaching device. As with geographic differences in disease, some knowledge of these modal factors in education can promote the uniqueness and relevancy of the indigenous institution.

With few exceptions, however, neither the content nor the mode of traditional (Western) medical education adequately prepares medical graduates to deal effectively with many of the problems as they really exist in some developing countries. The idea that the simple explant of any archetype western medical school selected for its "excellence" will automatically provide any other part of the world with equivalent excellence is slowly beginning to be recognized as a superficial and undesirable generality.

The visiting pedagogue to the developing nation is, of course, also subject to many geographical and educational differences. Although his lectures and discussions may be scientifically accurate and factually up-to-date, he may be a hemisphere re-

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*Bangkok Post, August 3, 1967

moved from what is locally important. In addition, his background of technologic and personal affluence may be more hindrance than help unless he learns to use facilities and services which are actually available rather than proposing as a solution to local problems the acquisition and development of what he is accustomed to. This can be an exceedingly difficult adjustment.

Finally, Geographic Pathology may also take into consideration the various stages in the natural history of disease as it occurs in the community and emphasize the inclusion of this information into the medical curriculum. An appreciation for the predominant stage of a disease can potentially influence many aspects of institutional planning and service. Haagensen[22] in his text, *Diseases of the Breast,* observed that one of the most important factors in predicting the presence of auxillary metastases in breast cancer, and hence survival, is the socioeconomic status of the patient. He pointed to the significantly higher incidence of metastases in patients admitted to charity wards as compared with those admitted to private services. The moral issue facing medicine which is implied in these data is clear enough. The magnitude of the problem, however, in a poor and semiliterate population which has either minimal health knowledge or none at all is truly enormous. In north Thailand, about 90% of women with breast cancer have axillary metastases when first seen by a physician. In such a population, at least in the early phases of development of medical services, breast cancer is primarily a problem of public health education and not one of providing multiple sources of cobalt 60 for palliation.

In summary, knowledge of geographic differences in disease can help determine the relevancy of institutions responsible for the health of the community, and if modern medicine is to meet the demands of the future, it must above all else be responsive to the reality of human needs.

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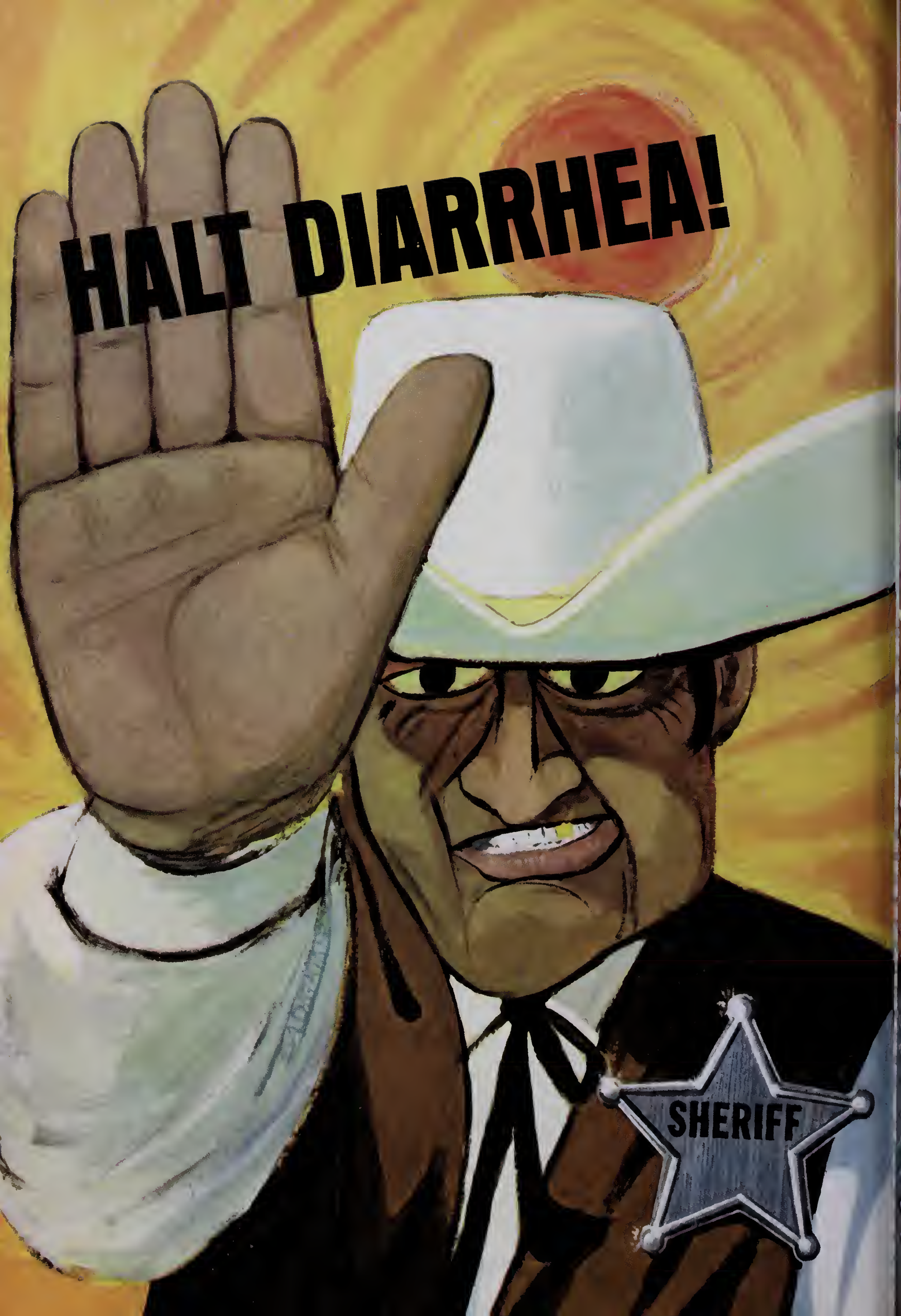
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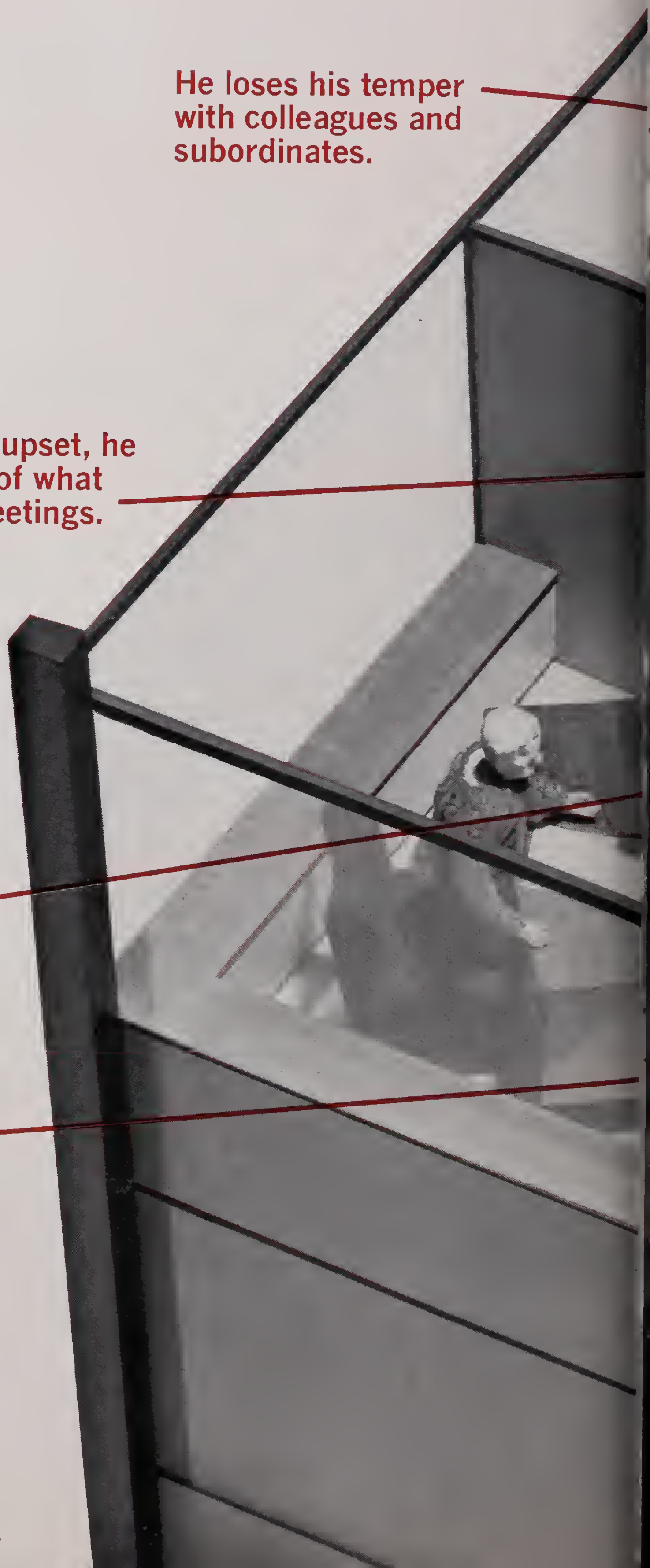

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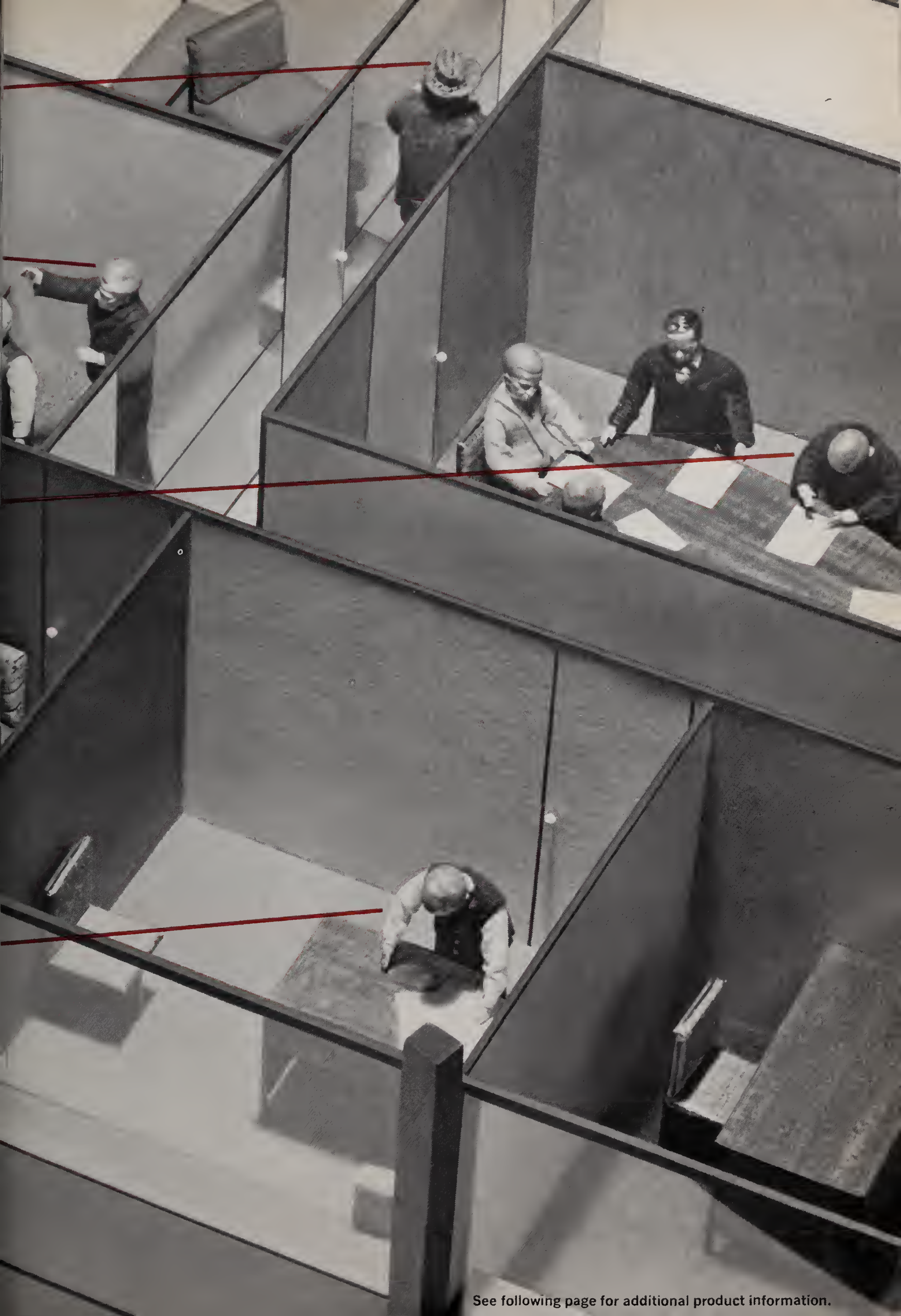

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The Emergency-Room Psychiatrist; A Report During the Detroit Riot

BY LARY R. BERKOWER, M.D.
DETROIT

ABSTRACT — The emergency room psychiatrist, ordinarily a resident, fulfills a vital function in making emergency evaluations and dispositions of acutely disturbed patients in a large city hospital. A description of emergency room practice at Detroit General Hospital during the July, 1967 riot is provided. Several cases are presented illustrating how the riot situation aroused unbearable instinctual forces in patients with weakened egos. These forces were unsuccessfully defended against by the patients' psychopathological defence mechanisms. Considerations in the evaluation and disposition of these patients are discussed.

One of the least recognized, yet very relied upon figures in the medical community of a large city is the psychiatrist, ordinarily a resident, working in the emergency room of the metropolitan hospital. He is responsible for making dispositions upon urgent psychiatric problems, and often he is the only person in the city in a position to do so. In the midst of all the turmoil of a crowded emergency room immediate evaluations and decisions must be made by him concerning emotionally disturbed patients which may have lasting consequences to them and their families. It should be added that the duties of the emergency room psychiatrist preceded the present era of community psychiatry, and from all indications, there has been no reduction in the need for his services.

Thus, the physician in the city with an acutely agitated patient requiring immediate psychiatric attention knows to whom he can turn at all times for help.

From the viewpoint of the psychiatrist in the emergency room of a busy city hospital, such as Detroit General Hospital, this work is a challenging and hectic experience. One encounters almost every form of psychopathology described in textbooks over a short period of time. Such entities as Korsakoff's psychosis, waxy flexibility, and acute alcoholic hallucinosis are relatively familiar sights in the emergency room, though rare elsewhere. Psychologically, the variety of ways people deal with overwhelming feelings and life situations is a constant source of surprise despite many years of training. Of course, any prevalent disaster in the hospital area increases and compounds the pre-existing degree of challenge to the psychiatrist in the emergency room.

THEREFORE, WHEN MY 24-hour tour of psychiatric duty occurred during the massive Detroit riot of the week of July 23, 1967, I was unusually eager to grapple with the acute emotional reactions which would surely arise. How, I asked myself, would the rampant rioting, burning, looting, and sniping color and precipitate disturbed forms of behavior requiring immediate psychiatric attention? The following are some of the observations I made during this unforgettable period at Detroit General Hospital.

To begin with, the hospital was surrounded by national guard and army troops on all sides, some of whom were holding prominently their guns and bayonets. Many Detroit policemen were also present, especially since the hospital is located downtown opposite the main city police station. Reporters, photographers, and newscasters were seen all around the hospital. At the ambulance entrance, as a part of the disaster plan in force, cots were lined up so that injured victims could be brought into the emergency room more quickly. Doctors, nurses, and hospital aides were waiting outside throughout the night to receive patients.

Thus, the busy atmosphere about the hospital had an unusual, sensational quality; everyone knew that they were a part of the national news of the day. In spite of all the police and federal protection a certain degree of peril seemed to be

Continued on Page 206

Doctor Berkower is a graduate of Wayne State University Medical School. He interned at Sinai Hospital, and then served two years in the U. S. Air Force, stationed at Selfridge Air Force Base. He began his psychiatry residency at Detroit Psychiatric Institute, which is the psychiatry department of Detroit General Hospital, in September, 1965.

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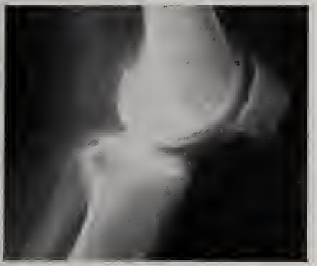

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But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

holding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. It is usually unnecessary to exceed 4 tablets daily. A trial period of 1 week is adequate to determine response; in the absence of a favorable response, discontinue. Maintenance: An effective level is often achieved with 1 or 2 tablets daily, do not exceed 4 daily. 6562-VI(B)R2

For complete details, please see full prescribing information.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

TA-5806

present raising the level of tension, since snipings and rumors of snipings were occurring every hour in the city.

RIOT VICTIMS FILLED the rooms and halls of the emergency area. Most of them were suffering from gunshot wounds, burns, and lacerations. Patients, both perpetrators and victims of the riot, were crying out in pain while receiving intensive medical attention. The instigators of the riot were easily distinguished by their handcuffs and leg restraints, since they were police prisoners. Some of them were addicts suffering from withdrawal symptoms. At times television photographers were taking films while the doctors and their assistants were at work. One could view the familiar hospital personnel on television later in the day on news programs.

Though staff fatigue was obvious, everyone seemed to be functioning on a special reserve of physical and psychological energy with no loss in efficiency. Detroit General was operating under its disaster plan, which contributed to the overall success in meeting the emergency needs of the community. In addition, many members of the outside teaching staff of the Wayne State University Medical School converged upon Detroit General during this period, and actively participated in patient care. Although Detroit General is the main teaching hospital of the medical school, the presence of so many noted practitioners at one time was unusual, as well as very beneficial.

During all of this, psychiatric patients trickled into the hospital. Those suffering from comparatively mild anxiety reactions were screened by the medical staff, calmed, and provided tranquilizers where this was considered necessary. The more severely disturbed patients were seen by the psychiatry resident in charge. Some of the remarkable emotional reactions precipitated by the riot which I encountered include the following:

THE FIRST PATIENT of the day was a 22-year-old single male (Mr. D.) who had been intercepted by the police after wandering in and out of the hospital building. At one time he was seen roving through the corridors of the fourth floor of Detroit General. In the past he had been treated as an outpatient by another hospital in our area. Mr. D. openly stated he was an FBI agent and was in search of snipers. When he was processed by the administrative staff he threw his draft card on the table and claimed this was his FBI identification. During our interview he refused to discuss what brought him to the hospital, maintaining he was an FBI agent and should at least have representation by his lawyer. The patient appeared as a confused, distant, and fearful individual with loosened thought processes compatible with schizophrenia.

It was my impression that Mr. D. had defended himself from the stresses and lawlessness of the riot situation by withdrawing from reality and entering his delusional world as an FBI agent, thus surmounting his impulses. Yet there was a sufficient amount of reality testing present that enabled Mr. D. on his own to come to the hospital where psychiatric help could be obtained. Under the circumstances I had no choice but to hospitalize this disturbed individual.

ANOTHER UNUSUAL RESPONSE to the riot atmosphere was that of a 17-year-old girl (Miss O.) who was living in common law with a 21-year-old man not far from the center of the city disorder. The girl had been raised in foster homes and had received previous psychiatric treatment. She and her boy friend had quarreled the previous night, and the patient had briefly left their apartment afterward. The next day, while her boy friend was working, three small fires broke out in their apartment. Little damage resulted since they were quickly put out. After one of the fires Miss O. telephoned her friend urging him to return to her immediately. The patient was first seen by the police department, which referred her to our hos-

Continued on Page 208

AUTHOR
BERKOWER

Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth pital. When I talked to Miss O. she insistently denied setting the fires. She appeared alert and coherent, though there was a sad and bewildered quality to her affect. Therefore, I contacted her neighbor who presented unmistakable evidence that the patient was the only person who could have caused the fires; the neighbor was understandably frightened by Miss O. The patient persisted in her story when I confronted her with this, though she wept. I concluded that some psychological dissociation and regression had occurred in this emotionally immature young lady leading to her behavior and amnesia. The more usual suicidal gesture by ingestion or wrist slashing was replaced by the fires under the influence of widespread arson in Detroit. Miss O. was hospitalized overnight while a "rescue" by her boy friend took place and she stabilized (with appropriate psychiatric counseling) away from her charged environment.

A THIRD TYPE of reaction to the riot was that of a 40-year-old married white cab driver and property owner with no previous psychiatric or criminal record. He was a police prisoner after having been arrested for carrying a weapon while walking on his street. The patient, Mr. M., insisted this was for self-protection, and he was innocent of any wrongdoing. While in his jail cell with seven other prisoners, some of whom were arsonists, looters, and snipers, Mr. M. went into a panic. He started trembling, became short of breath, cried, and fainted. Marked anxiety was still present when I interviewed him in the emergency room. I was able to help Mr. M. relieve much of his acute anxiety by letting him ventilate his pent-up feelings of having been wrongfully accused by the police and his fears concerning the other prisoners, who were largely negro. Mr. M. related much of his panic to his childhood when he was afraid of being beaten up by bullies on his block. After the twenty-minute interview the patient was sufficiently relieved that he could return to his jail cell quite calmly.

THE FORM OF psychotic denial of reality and delusions during the riot period was interestingly affected by the surrounding civil disturbance. Thus a 40-year-old separated lady with a long history of schizophrenia wandered into the hospital in search of her six children. They had been placed in foster homes several years before due to her illness. The lady, Mrs. S., was convinced her children were in Detroit General Hospital, and she wished to reclaim and save them from the chaos. While I talked to her she hallucinated a son before her eyes, as if fulfilling her wish by transforming illusion into reality.

Another 36-year-old lady with a four-year history of mental illness started fasting and not sleeping during the riot. She heard voices of people wanting to kill her, and she contrasted this with her "love of humanity." This lady became frightened when an aide passed by during our interview because she was afraid he would shoot her. In this manner the patient warded off and projected her own forbidden aggressive feelings. One more reaction to the riot was that of a 17-year-old girl who went into a catatonic stupor as a result of overwhelming impulses provoked during the riot.

In these and many other ways the psychological impact of the riot was to arouse in patients with weakened egos unbearable instinctual forces. These were unsuccessfully defended against by such psychological mechanisms as denial of reality, dissociation, regression, projection on to others, and withdrawal into delusional thinking. The experience of treating these patients during this traumatic period was an exciting and memorable one. Serving with the rest of the dedicated and united staff of Detroit General Hospital as emergency room psychiatrist was a rewarding opportunity.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

**a stuffy nose
is no
laughing matter**

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules
brand of sustained release capsules

**each one can
give him all-day
or all-night relief
of nasal congestion**

SK&F Smith Kline & French Laboratories

Where Does MSMS Stand re Legislation, Forensic Medicine, Laws, Regulations?

The MSMS publication *Where We Stand* points out some questions which need answers "some in the very near future" and this may especially be true in the area of legislation, forensic medicine, laws, and regulations governing medicine.

The booklet, written this past summer by Hugh W. Brenneman, MSMS executive director, has been studied by The Council and The MSMS House of Delegates.

The booklet covers 13 subject areas and three have already been reprinted in the December and January issues of *Michigan Medicine*. Other sections will follow.

The booklet is helping to serve as a guide for the Michigan Health Information Research Institute, which was authorized by the 1967 House of Delegates. The independent institute is to be established "to obtain correlate and report upon research in the distribution of health care."

The *Where We Stand* workbook has been described as "an analytical overview of some of the current concerns and activities of MSMS and related, emerging, unanswered questions."

The chapter in the booklet on "Legislation, Forensic Medicine, Laws and Regulations Governing Medicine" raises many questions after a discussion of the subject.

The following is quoted completely:

LEGISLATION, FORENSIC MEDICINE, LAWS AND REGULATIONS GOVERNING MEDICINE

Discussion

Enforcement Authority

The MSMS does not have the legal authority to enforce the laws which regulate the profession because it was established for scientific and educational purposes, not for the exercise of legal authority. Because of this, and because all members of the profession in Michigan are not members of MSMS, it cannot stop an incompetent doctor from practicing or discipline a nonmember.

Citizenry Control of Medicine

The profession of medicine as a part of the total society is regulated and controlled by the laws of the state (not alone by MSMS principles) and thus is subject to the will of the citizenry expressed through the license to practice. When legitimate public concern is expressed through the introduction of bills which might affect the manner in which medicine exercises its privilege of practice, MSMS must give such bills the most serious consideration. Otherwise, unduly restrictive laws might be adopted.

Number of Bills Increased

The number of bills affecting the practice of medicine has increased both in number and in scope. The activities of MSMS in providing information and advice to the Legislature have increased. MSMS is having a hard time keeping pace with the accelerated tempo of legislation caused by Michigan's "full-time" Legislature. Although a larger number of physicians read the bills, know something of the laws, and are in a position to obtain and evaluate factual information, understand practical implications, and formulate reasonable legislative presentations, the increase is not significant in comparison with the need. MSMS needs rapid readjustment in this area, particularly to provide for contingencies which require special handling and for back-up staff members to understudy key staff personnel.

Staff Personnel

MSMS and its members must be both willing and capable of assisting government in making modifications of medical licensure and the legal environment in which it practices and do so for the benefit of all society, not just the profession. MSMS has recognized this in its recent approval of the single medical practice act concept.

Modifications of Licensure

Despite various strategies, including the holding of sessions between legislators and doctors from their home towns, the establishment of a first aid service, the preparation of much material for hearings, etc., MSMS needs to increase its efforts in this field just to stay even.

Also, MSMS is faced with statutes which regulate *portions* of the practice of medicine, such as the PKU law and measles and tuberculosis immunization statutes. Are these in the public interest? Are additional ones to be avoided?

PKU
Measles and TB
Immunization

MSMS is concerned about the expansion of practice privileges sought by practitioners of podiatry, optometry, psychology, etc., not because of any additional competition that might be engendered but because the MD is not convinced that these limited licensees can safely practice in expanded areas. This position of MSMS is not generally understood by the public, and the practitioners of these arts have sought in some instances to further confuse the Legislature. A study is being sought in the Legislature which could result in a solution to this problem (see Appendix B for Resolution HCR 88).

Podiatry
Optometry
Psychology

Health Arts Practice Study

Allied with this is the responsibility which the profession has taken upon itself to oppose cultism in or outside the Legislature. This becomes especially acute as government enters the picture and arbitrates who can and cannot practice under governmental care programs.

Cultism

Incidentally, one area of legislation which MSMS feels a strong interest in, and which is now in turmoil, is that involving other professions and professional associations. Legislation or regulation, for example, which would change the tax liabilities of trade and professional associations could have a deleterious effect on MSMS. The same is true of legislation which might extend the Use Tax to professional services.

Professional Associations Legislation
—Unrelated Income
—Use Tax on Professional Services

It should also be commented that progress is being made. In 1967 legislation was passed among which were such acts as these: The State Board of Registration in Medicine may now recognize the certificate of the National Board of Medical Examiners; blood transfusion has been legally declared a service, not a sale; a new hospital licensing law (specifically excluding the "franchising" concept) has been passed; the Nurse Practice Act has been rewritten, etc.

Progress
National Board of Medical Examiners
Blood Transfusions a Service
Hospital Licensing
Nurse Practice Act

MSMS has been very careful to live within the law and its incorporation charter — e.g., it has adhered to the Civil Rights Acts, concerned itself with accu-

Civil Rights
Financial Records and Taxation

rate handling of finances in relation to taxation requirements, etc., albeit at some expenditure in time and money.

Questions

Medical Examiner System

A. Should MSMS develop a statewide medical examiner system for all counties in Michigan and push for its adoption by the Michigan Legislature?

Medical Testimony

B. Should medical expert panels be supplied by MSMS for

1. Malpractice cases?
2. Workmen's Compensation cases?
3. As a service to the court when it is unable to obtain satisfaction in cases of disputed medical testimony?

Future Legislative Needs

C. Should a Legislative Research Committee be established to make a continuing study of future legislative needs of the medical profession in Michigan by the MSMS?

Medical Education for the Legislature

D. Should MSMS conduct a teaching program at its headquarters, recruiting as students key members of government including the members of the Legislature — such a teaching program to cover in some depth the medical subjects where controversy is keenest, e.g., the eye, x-ray, orthopedics?

Group Practice of Medicine

E. Group practice of medicine is growing and raises questions relating to legality of corporate practice. At the same time, the public appears to like group practice under certain conditions. Should a special study be made of the legal as well as the ethical facets of group practice?

---

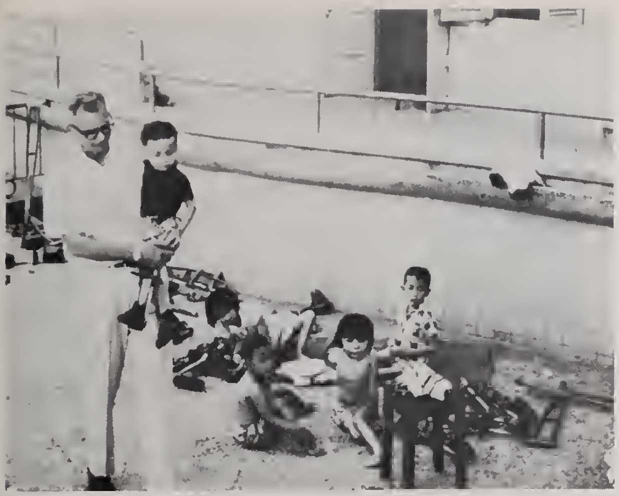
77 Percent of U-M Research Income from Government

The single largest sponsor of research at the University of Michigan during the year 1966-67 was the U.S. Department of Health, Education and Welfare, according to a recently published summary of U-M research expenditures for the past year. Of the total figure of almost $60 million, HEW provided 15.7 million largely from the biomedical programs of the National Institutes of Health.

A. Geoffrey Norman, U-M's vice president for research, pointed out in the report that much of the support for research continues to come from federal government agencies. The National Aeronautics and Space Administration was a substantial sponsor. Although the funds provided the U-M during the past year from the defense agencies amounted to almost 30 percent of the total expended, this percentage has been steadily declining as the federal research support base has been expanded.

The total of federal funds was $45.8 million, 77% of the total. University funds supplied $5.6 million and other support came from industry, private foundations, health organizations, and other sources.

A breakdown of the distribution of funds shows that the engineering sciences accounted for 31.6 per cent of the University's research expenditures, the life sciences 27.5 per cent, the physical sciences 21.3 per cent, the social sciences 14.8 per cent, and the humanities and others 4.8 per cent. In recent years there has been a substantial increase in the funds available for social sciences, life sciences, and the humanities.



SEE VIETNAM FEATURE, PAGE 248

The story of the Michigan doctors who have served in the "AMA Volunteer Physicians for Vietnam Program" is told vividly in a special feature, beginning on 248. In the photo above, Hugh C. Sulfridge, M.D., Saginaw, is shown with some of the children at an orphanage conducted primarily for crippled children by the Sisters of Charity at Can Tho.

Resolution Applauds Career Recruiting Work Of State Health Council

Michigan school counselors and others who participated in the Michigan Institute on Health Careers held recently near Battle Creek gave the Michigan Health Council a standing ovation for its efforts.

In a resolution adopted by the Institute, the counselors and other guests recognized the need for work in the health careers field.

The adopted resolution began, "Whereas, the problem of shortages in health manpower in this nation is critical and widespread, and whereas the public in general and educators in particular are only partially aware of this critical state and the role they can play in its alleviation; and whereas, the Michigan Health Council has seen the need to bring this problem forcibly to the attention of educators through their counselors the Michigan Personnel and Guidance Association . . ."

The resolution was presented by Mrs. Robert H. Fraser, coordinator, Health Careers Council of Calhoun County.

Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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WILLIAM H. RORER, INC.
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Emetrol®
phosphorated carbohydrate solution
emesis control

MEOO Director Ford Suggests Ways to Break Cycle of Poverty

WM. R. FORD
MEOO DIRECTOR

"It's devastating to an individual to be trained for a career in machine operation only to find out that the hiring restrictions exclude him because he only completed 11 years and 6 months of formal education.

"The system is stacked against the poor and disadvantaged who make up one-half of our urban dwellers.

"The college-bound youth are in a minority, but vocational education is still a nasty word.

"Quality day care must be a priority in every community and it must be done with or without federal funds."

Those are some of the views of William R. Ford, Director, Michigan Economic Opportunity Office.

Mr. Ford has declared that, "The cycle of poverty is indeed one of the most destructive and self-defeating traps which anyone can be a victim of. It breeds hopelessness, despair, alienation, helplessness and defeat.

"If we're honest, we have to admit to ourselves that often we become a part of 'the System' . . . the system that is stacked against the poor and the disadvantaged who make up one-half of our urban dwellers and over one-fifth of our total population in America."

The need for Michigan programs to help the unemployed, disadvantaged is stressed by Mr. Ford. He says, "We live in a most exciting time! Change social and technological, is sweeping our nation and at a rate that would frighten away the meek and the faint-hearted.

Mr. Ford declares: "Every day new problems and new priorities are before us in Michigan and the nation. We must seek to understand the underlying reasons and causes of riots, civil disorder and open street warfare before we can move onward with significant steps in defeating discrimination, poverty and unemployment, conditions which I feel breed discontent, and subsequently result in civil disorders.

"We cannot move too quickly lest by rapid action we forget to listen to those who do not always participate in change. We cannot move too positively unless by forward movement we mean subverting Democracy for a social dictatorship where the people become the secondary motives for our movement."

Day Care, Pre-School

Mr. Ford believes that some of the problems faced by the disadvantaged could be prevented or minimized by better programs in day care and pre-school. In part, he contends:

"One of the significant contributions of the local poverty programs in Michigan has been the institution of Day Care and Pre-School programs for mothers who could not previously find work because of their family responsibilities.

"In addition to releasing mothers for work or training or further education, Day Care has presented pleasant, school-type experiences to hundreds of children who may not have known these experiences without this kind of care.

"Interestingly, again, the poverty program has stimulated other Michigan agencies to look at their selection and education process to see if they were indeed contributing to the needs of our society's children.

"But there has been a less optimistic result of these programs and that is that a great door of hope was opened to thousands of women seeking to get off ADC and welfare rolls — only to have their hopes dashed because the facilities and the budgets were limited.

"Quality Day Care must be a priority in every community and it must be done with or without federal funds. The mothers and the children and, consequently, the future of America rests in the hands of those who can and will contribute to the search for independence and self-sufficiency on the part of those mothers who want to work."

Schools

Mr. Ford declares that "A good share of the future of America rests in the hands of educators, school boards, and local governments." He offers these views of the drop-out problem:

"The school drop-out personality is formed before or shortly after the child starts school. In the ghetto because of de facto segregation through neighborhood schools, the minority child is doubly disadvantaged. He learns soon not to expect much from the "jail" called school and the teachers often return the favor — they don't expect much from him, and, consequently, the decline of motivation, aspiration and interest occurs. By the time the child reaches young adult status, he is ill prepared to meet the demands of even the most menial job.

"It's a syndrome that never gets better particularly in our inner cities. But unfortunately now, that syndrome has grown even in the suburbs and farm communities of our nation."

Mr. Ford expresses an optimistic note about changes in education today:

"There are, however, faint glimmers of hope across the nation. In fact, school people today are looking to more creative solutions right here in Michigan. The Elementary and Secondary Education Act (1965) coupled with Economic Opportunity funds have made it possible for the educators to try new ideas, new theories to reverse the cycle, the syndrome of under achievement. Much attention is being focused in Michigan on the development of positive attitudes in teachers and pupils regarding their mutual relationship and the larger world of human development and understanding. Supplemental reading programs, counseling sessions in elementary schools hold some hope of breaking the cycle.

"But much more needs to be done. For example, we still direct 90% of the curriculum to 15% of the youth. The college-bound youth are in a minority, but vocational education is still a nasty word.

"Michigan schools must become the pre-apprentice workshops of our cities. They must begin to prepare skilled and semi-skilled craftsmen for the changing labor market. In this area, unfortunately, too little is being done to encourage those with skills and talents who want to work with their hands and their heads to pursue a realistic job-oriented trade.

Job Opportunities

"The most persistent problem in careers for the young people in Michigan cities is the problem of discrimination."

Mr. Ford says the federal civil rights Act of 1964 "was a heluful, yet devastating tool in the minority's quest of job opportunities. Today, discrimination has gone underground with culturally oriented qualifying entrance exams and education requirements — neither of which reflects the nature or complexity of the job to be performed."

The need in Michigan for skill training and manpower development is emphasized by MEOO Director Ford. He makes these observations:

"Michigan is the nation's leader in skill training and manpower development, but the barriers to open hiring and promotion by merit are still there. It is devastating to an individual to be trained for a career in machine operation only to find that the hiring restrictions exclude him because he's too heavy or too light in weight, because he only completed 11 years and 6 months of formal education or because his personality inventory indicated that he has hidden hostilities that don't fit into the pattern of a happy machine operator in our society. Or maybe he can't read well enough to put wheels on a new automobile at $4.75 per hour.

"Business, industry and government must begin to realize that the tax consumers in our soceity are capable of becoming tax producers if they are given a fair and equal opportunity. I believe no one — I repeat — no one really wants to be poor or unemployed. But those who are unemployed and poor are lost in a world of change in which they've never participated from the very beginning.

"A survey completed in Detroit in 1966 reported that trainees in a 1963 manpower program had already repaid in new tax revenues the money invested in their training. And that report did not include reduced welfare costs, subsidized housing or, more importantly, restored dignity and independence."

Mr. Ford, in discussing employment, declares that, "Much remains to be done. There are still nearly as many available jobs as there are unemployed people. Something creative must be done to bring the jobs and people together! Michigan State Department Civil Service has just now embarked on a campaign to hire the hard-core unemployed in aide positions in departments throughout the state. We must support and augment that program. Business and industry need a tax incentive to hire and train new employees. Or at least the extension of the current On-the-Job Training re-imbursement to open new jobs and new careers to poor people."

Recreation

Mr. Ford sees recreation as another key along with education and employment in the solution of the problems. He reports that "we anticipate summer programs soon in nearly every urban area in this state financed by OEO with 20% matching from the local community. Local organizations, agencies, government and especially the Michigan Youth Commission can assist in helping to form guidelines, new ideas, and new techniques. These experiences can help many individuals learn and grow in their understanding of the ghetto, the slum, the whole culture of poverty."

Local Involvement

The importance of local involvement in the study of and solution of the complex problems is stressed by Mr. Ford.

"Many lay organizations today are discussing and studying many topics that no one could discuss five years ago," he reports. He asks pointedly: "Was anyone talking about the participation of young people or for that matter participation of all consumers of service, the poor, the minority in the decision making process before 1964?"

Mr. Ford expresses his belief that "Community Action Programs or for that matter all OEO programs are not and will not be the panacea for poverty in our nation. Locally and nationally, OEO funds make up less than 1 - 2% of the monies being directed at socio-economic and human development.

"The 50 million dollars spent in OEO monies in Michigan is far short and almost insignificant in comparison to the 4.9 billion dollars of all federal monies being used in this state."

The needs for local citizens to participate voluntarily in action programs to provide better job opportunities, educational programs, and community-based neighborhood improvement projects are stressed by Mr. Ford.

Mr. Ford presents this challenge to Michigan residents:

"Involvement is a great concept, but it must mean the involvement in significant decision making of those who are victims of 'The System.' Only through courage, creativity, total involvement of youth and adults, and a lot of hard work can we serve as part of the alternative to 'The Fire Next Time.' "

* * *

(This article was developed by Managing Editor Herbert A. Auer from an address given by Mr. Ford to the Michigan Youth Commission. Several MD members of the Youth Commission suggested that all physicians would be interested.)

MANY MSMS COMMITTEES, GROUPS HOLD MEETINGS

Thursday, December 7
Regional Leadership Conference
Park Place Hotel, Traverse City

Friday, December 8
Committee on Mental Health
Statler-Hilton Hotel, Detroit
Chairman: Benjamin Jeffries, M.D., Detroit

Monday, December 11
Regional Leadership Conference
Mr. President Motor Inn, Grand Rapids

Tuesday, December 12
Advisory Committee to Executive Director
MSMS Headquarters
Chairman: Robert J. Mason, M.D., Birmingham

Wednesday, December 13
The Council
MSMS Headquarters
Chairman: Robert J. Mason, M.D., Birmingham
County Societies Committee
MSMS Headquarters
Chairman: John J. Coury, M.D., Port Huron
Finance Committee
MSMS Headquarters
Chairman: Robert K. Whiteley, M.D., Detroit
Publication Committee
MSMS Headquarters
Chairman: Brooker L. Masters, M.D., Fremont
Committee on Eye Care
MSMS Headquarters
Chairman: Robert T. Blackhurst, M.D., Midland

Thursday, December 14
Committee on Legal Affairs
MSMS Headquarters
Chairman: Otto K. Engelke, M.D., Ann Arbor

Monday, December 18
Regional Leadership Conference
Kingsley Inn, Bloomfield Hills

Wednesday, December 20
Liaison Committee with Michigan Chapter of Health Insurance Council
Sheraton-Cadillac Hotel, Detroit
Chairman: John J. Coury, M.D., Port Huron

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each Tussagesic® timed-release tablet contains:

Triaminic®	50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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clip and file under "flu"

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Representative

New Certificates Ask More Info from Doctors About Births, Deaths

Considerable discussion among Michigan doctors continues regarding the new certificates which became effective January 1 for live births, deaths, and fetal deaths.

Michigan physicians and those across the nation were required to use the U.S. Public Health Service revised standard forms on January 1.

The Public Health Service contends that the 1956 revision of the certificates did not ask for adequate socioeconomic information on birth certificates.

Governmental officials also point out that, "with present emphasis on comprehensive health planning based on factual data, the need for state-to-state comparisons of uniform vital statistics becomes essential."

Physicians are facing questions on the certificates that they are not readily able to answer.

Most of the new items on the forms appear in a special "Confidential" section. These items will not appear on certified copies of the records. The confidential section is part of the birth and fetal death certificates.

The section on race in the birth and fetal death certificates appears in the confidential section.

Following is a brief listing of the new items on the three forms. The reasons why the new information is sought are paraphrased from an explanatory Michigan Department of Public Health bulletin:

A) **Birth Certificate.** (To be recorded)

1. The hour of birth. This will be helpful as legal evidence, to document the order of delivery in the case of multiple births, and it may be useful in perinatal studies.
2. The relationship of the informant to the child. This will provide a source of contact for additional information or the correction of errors.
3. The education of both parents. This item replaces sections on occupation and kind of industry. It is regarded as a more stable and specific socioeconomic measure.
4. Date of last live birth and date of last fetal death. This information is used to measure child spacing.
5. Date of last normal menses. This replaces the length of pregnancy section.
6. Month of pregnancy prenatal care began. This information will be helpful in programs to reduce fetal and infant mortality.
7. Prenatal visits. This information will complement the section on the beginning of prenatal care.
8. Complications not related to pregnancy.

B) **Fetal Death Certificate.** The same *new* items listed under *birth certificates* are also on this certificate. In addition, there is to be recorded:

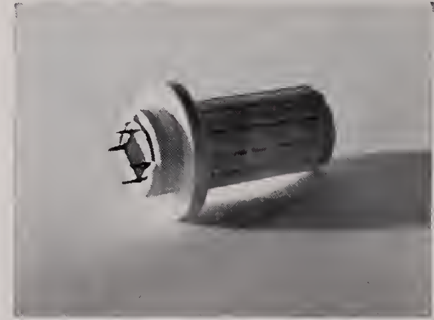
1. Cause of fetal death: specify fetal or maternal. This helps establish underlying cause of death and is useful on the pathology of fetal death.
2. Autopsy: if Yes, were findings considered in determining cause of death? This helps provide evidence of the reliability of cause-of-death certification.

C) **Standard Death Certificate.** What follows are new items to be recorded on the death certificate:

1. Surviving spouse. This information is useful in cases of inheritance, social security claims, and veterans benefits.
2. Autopsy: if Yes, were findings considered in determining cause of death?
3. Certification. Physician is asked to indicate whether or not he saw the body after death and to certify place of death, dates of attendance, date last seen alive, date of death, and cause (s).
4. Cause of Death. "Or as a consequence of" has been added to allow the physician to enter a cause from an underlying time sequence which leads to death, but is not considered strictly cause-effect. For example, terminal pneumonia following a stroke might be considered a "consequence of" rather than "due to" stroke.

To fight TB-
find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN,TINE TEST
(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.

Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weigh (increase or decrease), changes in cervical erosion and cervical secretion suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmona embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

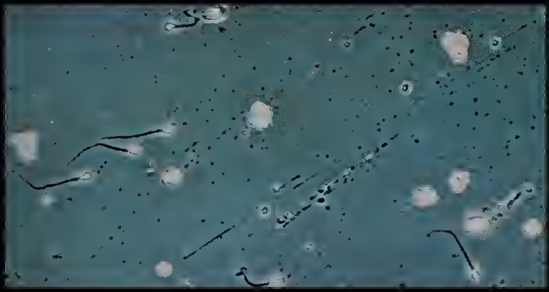
norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF

Here's why Norinyl-1 makes medical sense.

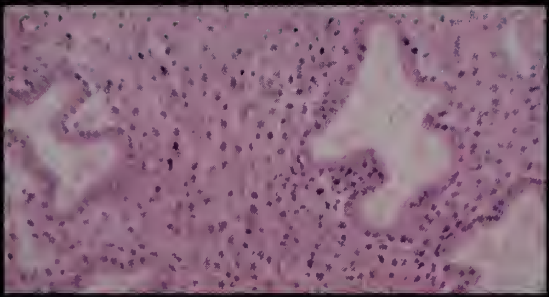
The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

Untreated Patient

Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



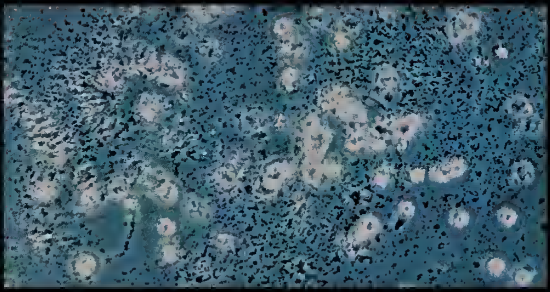
Spermatozoa appear healthy, active, freemoving.



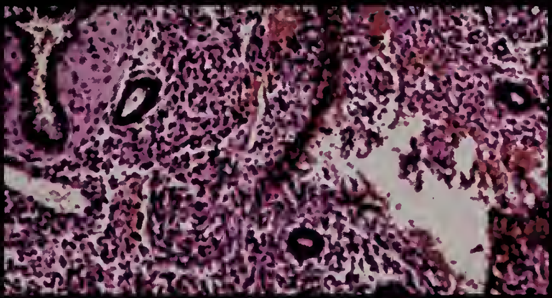
Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

Norinyl-1 Patient

Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. c̄ mestranol 0.05mg.)

- new low dose of time-proved ingredients
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- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide

Turn page for contraindications, precautions and side effects.

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide

provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream — 5, 15 and 60 Gm. tubes.

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SYNALAR®
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Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming),
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■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

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Annual Conference for Michigan Health Planning Set for Detroit, Feb. 22-23-24

Every MSMS member is invited to participate in the First Annual Conference for "Michigan Health Planning and Related Subjects," in Detroit, February 22-23-24.

The conference will be sponsored by MSMS in cooperation with other statewide health associations and agencies in Michigan.

The program for Thursday, February 22 will focus on "The Doctors, Law and the Courts."

The emphasis Friday, February 23 will be on "Health Planning and Its Affect on Physicians, Hospitals and Communities."

The Annual MSMS Conference for Component Society Leaders will be held on Saturday, February 24.

Detailed programs and registration forms are being mailed to every MSMS member, and to many special invitees.

"Some members will be able to attend all three days — but if you cannot, please pick out the day or days that interest you the most and come for those," points out President Harris. A nominal registration fee will be charged for February 22 and 23 to help defray the expenses.

Thursday, February 22

The program for Thursday, February 22 at the New Center Motor Lodge will feature top-flight attorneys, judges, legislative representatives and physicians. The subjects, listed on the inside back cover of this issue of *Michigan Medicine,* will deal with such vital everyday subjects as malpractice, privileged communications, the doctor in the courtroom, revision of the Michigan criminal code, revision of the Michigan medical practice act, and new legislation in Washington and Lansing.

Friday, February 23

The timely topics for Friday, February 23, also at the New Center Motor Lodge, will provide doctors with insights into the recent recommendations of the National Advisory Commission on Health Manpower, and the developments in Michigan to implement the Comprehensive Health Planning Law (PL 89-749) and the Heart, Cancer, Stroke Law (PL 89-239) and the implications of all three to private practice. The program also will discuss "The Voluntary Approach to Health Planning."

Component Societies Conference

Saturday, February 24 will be the annual MSMS Conference for Component Society Leaders at the Wayne County Medical Society Headquarters. The officers and the legislative and public relations chairmen have been invited to an informational program that will provide workshops and also opportunities to discuss legislation, politics, ethics and professional conduct, public relations, and quackery education.

Some Speakers Listed; Others Coming Too

THURSDAY, FEBRUARY 22

"THE DOCTORS, LAW AND THE COURTS"

—D. F. Doehrman, General Manager, Medical Protective Company, Fort Wayne, Indiana

—Judge Horace E. Gilmore, LL.B., Wayne County Circuit Court

—Jerold H. Israel, Professor, University of Michigan Law School

—Joseph B. Bilitzke, LL.B., Lansing, Assistant State Attorney General

—Bernard D. Hirsh, LL.B., Director, AMA Law Department

—Ernest B. Howard, M.D., Assistant Executive Vice-President of the AMA

FRIDAY, FEBRUARY 23

"HEALTH PLANNING AND ITS AFFECT ON THE PHYSICIAN, HOSPITAL AND COMMUNITY"

—Harold Margulies, M.D., Washington, D. C., one of the key men in the National Advisory Commission on Health Manpower and its Report.

—Michigan Lieutenant Governor William B. Milliken

—Dean William N. Hubbard, Jr., M.D., President, Michigan Association for Regional Medical Plans

—George W. Slagle, M.D., Battle Creek, Chairman, AMA Council on Medical Service

SATURDAY, FEBRUARY 24

"MSMS CONFERENCE FOR COMPONENT SOCIETY LEADERS"

—The Honorable Frank J. Kelley, LL.B., Michigan Attorney General

—Doyl Taylor, LL.B., Director, AMA Department of Investigation

—C. Darrell Coover, AMA Washington Office

—MSMS Officers, and others

COME TO FEBRUARY CONFERENCES

The Best We Can —Is Better Together

Today's doctor is expected to be a paragon of virtue, a superb administrator, a community leader, an unparalleled healer, the captain of the health team and a health authority; not to mention such additional qualities as being a family man, a pillar of the church, an active participant in medical society affairs, and it helps if he keeps in athletic trim by participation in golfing skiing, etc.

SIMILARLY, THE STATE AND county medical societies are expected to be authoritative sources for all scientific medical advancements, participants in all governmental health planning, experts in legislation of practically all varieties, highly influential in political matters, economic sages in health-hospital-medical insurances. They must publish scientific journals, arrange and sponsor post graduate education, filter all pharmaceutical and technical proposals and advertising, and act as father confessor to all members of the profession at the same time shielding them from the more gauche varieties of public wrath resulting from inevitable professional indiscretions.

Knowing the limitations of both human and organizational conduct, no reasonable man could expect the doctor or his organization to be 100 percent successful in living up to the expectations listed above. The answer is that *we do the best we can.*

On the other hand, it has been demonstrated repeatedly over the years that we do the best we can *better* if we act together as a profession and through our country and state medical societies.

BY PRESENTING A UNITED front, we make fewer mistakes, our services are more altruistically motivated and we maintain standards that are of advantage both to our patients and ourselves.

In the scientific medical field, we are glad to share responsibility between our medical society, our hospital staffs and our specialty groups. But in the field of health planning (categorical or comprehensive), and particularly in respect to its legal-sociological-political-economic elements, the medical societies must be primary. The fact that these elements are now playing a part equal to that of scientific medicine in the "warp and woof" of the average doctor's practice is no longer subject to argument; and the changes in these non-scientific matters are coming as rapidly as the changes in scientific medicine.

It was with all of the above thinking in mind that a new meeting for the total membership has been developed. Its sessions begin at 9:30 a.m. on Thursday, February 22, will continue through the 23rd with the third day being an annual county medical society officers conference.

THIS MEETING, which will be held at the Howard Johnson's New Center Motor Hotel in Detroit (near Fisher Building) will do one thing if nothing else: It will assist the person attending it solve some of the legal-sociological-political-economic questions which beset him in his daily practice. In doing so it will profit him as well as his patients.

We think at least one doctor from every medical office in the state should attend. Many non-doctors whose daily work directly affects the practice of medicine will also be present to hear and discuss the most recent proposals, with state and national authorities. This new meeting is recognition by the MSMS that neither the doctor nor his organization is quite able to do everything perfectly, but that as they do the best they can — *they can do it better together.*

100 YEARS OLD!

The Kalamazoo Academy of Medicine began its second century of service in January. It was on January 8, 1868 that six physicians began the "Kalamazoo Medical Association." Seven years later the name was changed to Academy.

Judicial Group Reaffirms Stand Re Rx Blanks

The MSMS Judicial Commission, at a recent meeting, studied and reaffirmed the position that, "It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon," reports Donald J. Sweeny, Jr., M.D., Chairman of the Commission.

The statement was a reaffirmation of a 1964 opinion of the Judicial Council of the AMA.

The Michigan State Pharmaceutical Association has been asked to inform pharmacists of this viewpoint.

Did You See Article About Seat Belt Injuries, Page 171?

Have you read the extensive article in the February issue of *Michigan Medicine* about "Lap Seat Belt Injuries: The Treatment of the Fortunate Survivor"?

The authors agree with the AMA Committee on Medical Aspects of Automotive Safety favoring the shoulder-lap system. In April, 1967, the AMA Committee urged the Engineering Advisory Committee of the Automobile Manufacturers Association for an overall seat design development to include a lap belt, upper torso restraint and adequate head protection.

Did You Save January Extra About Legislation?

Every member has been urged to keep in a handy place the January News Extra issue of *Michigan Medicine* because it was designed as a Special 1968 Legislative Supplement.

Important stories — for future reference — dealt with the status and location of the bills of primary concern to MSMS, with the membership of key House and Senate committees, etc.

Stewart Coming For SAMA Conclave

Principal speaker at the SAMA Awards Banquet on Thursday, April 25, in Detroit will be William Stewart, M.D., U.S. Surgeon General.

The Awards Banquet is part of the program of the 1968 national convention of the Student American Medical Association which will be held in Detroit, April 23-27. The WSU SAMA unit is serving as hosts.

Further details on speakers and topics will be carried in *Michigan Medicine.*

New Abortion Laws, Topic for Maternal Meet

One of the speakers at the Maternal Welfare Conference in Flint, March 26 and 27, who will shed some light on the controversial question of changing state abortion laws is E. Stewart Taylor, M.D., Professor and Chairman of the Department of Obstetrics-Gynecology, University of Colorado Medical Center, Denver. Colorado has recently liberalized its abortion laws.

Doctor Taylor is a former Flint resident, having taken his internship at Hurley Hospital in 1936-37, after receiving his M.D. degree at the State University of Iowa.

STANDER

TAYLOR

He is the author of many scientific papers and several manuals in the field of obstetrics-gynecology.

Doctor Taylor will speak at 3:00 p.m., Tuesday, March 26, on "New Abortion Laws."

Another prominent authority in obstetrics-gynecology who will be speaking at the conference is Richard W. Stander, M.D., Professor and Chairman of the Department of Obstetrics-Gynecology, University of Cincinnati College of Medicine. Doctor Stander was born in Grand Rapids. He was graduated cum laude from the University of Michigan Medical School in 1951, where he also took his internship and residency; later becoming an instructor at U-M Medical School.

Doctor Stander will discuss "Intrauterine Pressures" at 1:30 p.m., March 26.

This year the Maternal and Perinatal Welfare Conference is being held on Tuesday and Wednesday, March 26-27 at the Pick-Durant Hotel in Flint. There is no registration fee and both physicians and the public are invited. A complete program can be obtained from MSMS headquarters, P.O. Box 152, East Lansing.

Smoking-Health Efforts to Focus On Grade School

Several educational programs for 1968 are being developed and launched by the Michigan Council on Smoking and Health.

The Council, at its recent annual meeting, also reviewed 1967 activities and elected officers.

George Pickett, M.D., Detroit, was elevated from vice-chairman to chairman to replace Elizabeth Wheeler, Dr. P.H., Mt. Pleasant. Herbert A. Auer, of the MSMS executive staff, was elected as the new vice-chairman and J. A. Doherty, executive director of the Michigan Health Council, was renamed secretary-treasurer.

MSMS and the seven other supporting Council agencies participated in the annual meeting.

The major Council activity this past year, with the help of physicians in many communities, was a state-wide educational program with the Michigan Congress of Parents and Teachers. Leadership training conferences this past year will lead to local programs and local projects in the neighborhood PTA's.

This coming year the Council will relate to physicians, youth, parents and teachers in various educational programs. Major emphasis will be placed on students in the elementary grades.

U-M HELPS MALAYSIA

Under a $292,000 Ford Foundation grant, the Center for Population Planning and the Population Studies Center at the University of Michigan will assist the Family Planning Board of Malaysia. The U-M will provide consultants and specialists, train Malaysian staff members in the U.S., cover the cost of a population survey analysis, and provide books and equipment for population studies.

Mumps Vaccine Advice Given

The federal government has licensed a live, attenuated mumps virus vaccine especially recommended for adolescent and male adults who can become sterile from the relatively innocuous childhood disease.

The vaccine, developed over a five-year period by the Merck, Sharp and Dohme Research Laboratories, was not recommended for routine use in infants and young children pending development of more information in the duration of the immunity it provides.

William H. Stewart, M.D., U.S. Surgeon General, said excellent protection against naturally occurring mumps has been observed for the first year after the single-infection live vaccine.

"But limited data on natural exposure during the second year indicate continuing protection although additional observation will be required to determine the duration of immunity protection," he said.

* * *

The U.S. Public Health Service Advisory Committee on Immunization has issued recommendations which have been relayed to county health departments by the Division of Epidemiology of the Michigan Department of Public Health. The U.S. recommendations, in part, state:

"Live mumps vaccine may be considered for use in children approaching puberty, in adolescents, and in adults, especially males, if they have not had mumps. The single individual dose recommended by the manufacturer should be employed. The vaccine is not specifically contraindicated for younger children, but the vaccine is not recommended for routine use."

The American Academy of Pediatrics Committee on Control of Infectious Disease also has issued an official statement. In part, the AAP declares: "Until more definitive information is available with respect to duration of immunity, the AAP Committee does not recommend the routine use of mumps vaccine for all infants and children." The AAP Committee recommends the vaccine for the following "if they have not had clinical mumps: boys who are approaching puberty; adolescent and male adults; and children living in closed institutions, perhaps in summer camps or under other similar epidemiological circumstances."

Two State Colleges Hear AMA Lecturer

An AMA lecture on clinical nutrition by Professor Edgar Gordon, M.D., will be given at Western Michigan University in Kalamazoo, February 6 at 8 p.m.; and at Northern Michigan University in Marquette at 8:15 p.m., Wednesday, April 3.

This past fall, Doctor Gordon gave lectures in nutrition at Hope College, Central Michigan University, and Ferris State College. He is presently professor of medicine and chief of the metabolism and endocrinology clinic at the University of Wisconsin Medical School.

Add: In Memoriam

In addition to the names reported in the January "In Memoriam" the following news has reached the MSMS office. Details will follow in the February issue of *Michigan Medicine*:

Harold D. Dykhuizen, M.D., 59, Muskegon, died November 25.

Donald F. Kudner, M.D., 71, Jackson, died December 13.

Elmer L. Whitney, M.D., 81, Detroit, died December 29.

NEEL LEADS EXPEDITION

A University of Michigan medical team has recently departed for the jungles of Venezuela to study the Yanomama Indians, primitive tribesmen still living in a Stone Age culture. Headed by James V. Neel, M.D., chairman of human genetics at U-M Medical School, the team will spend two months making medical, anthropological, and genetic studies of the Indians.

NIH Director Will Keynote WSU Symposium

James A. Shannon, M.D., Director of the National Institutes of Health, will deliver the opening address at Wayne State University's Centennial Symposium on "Extending the Life Span: The Impact on Man" in Detroit, February 15 and 16. The banquet address will be made by Wayne State University President William R. Keast.

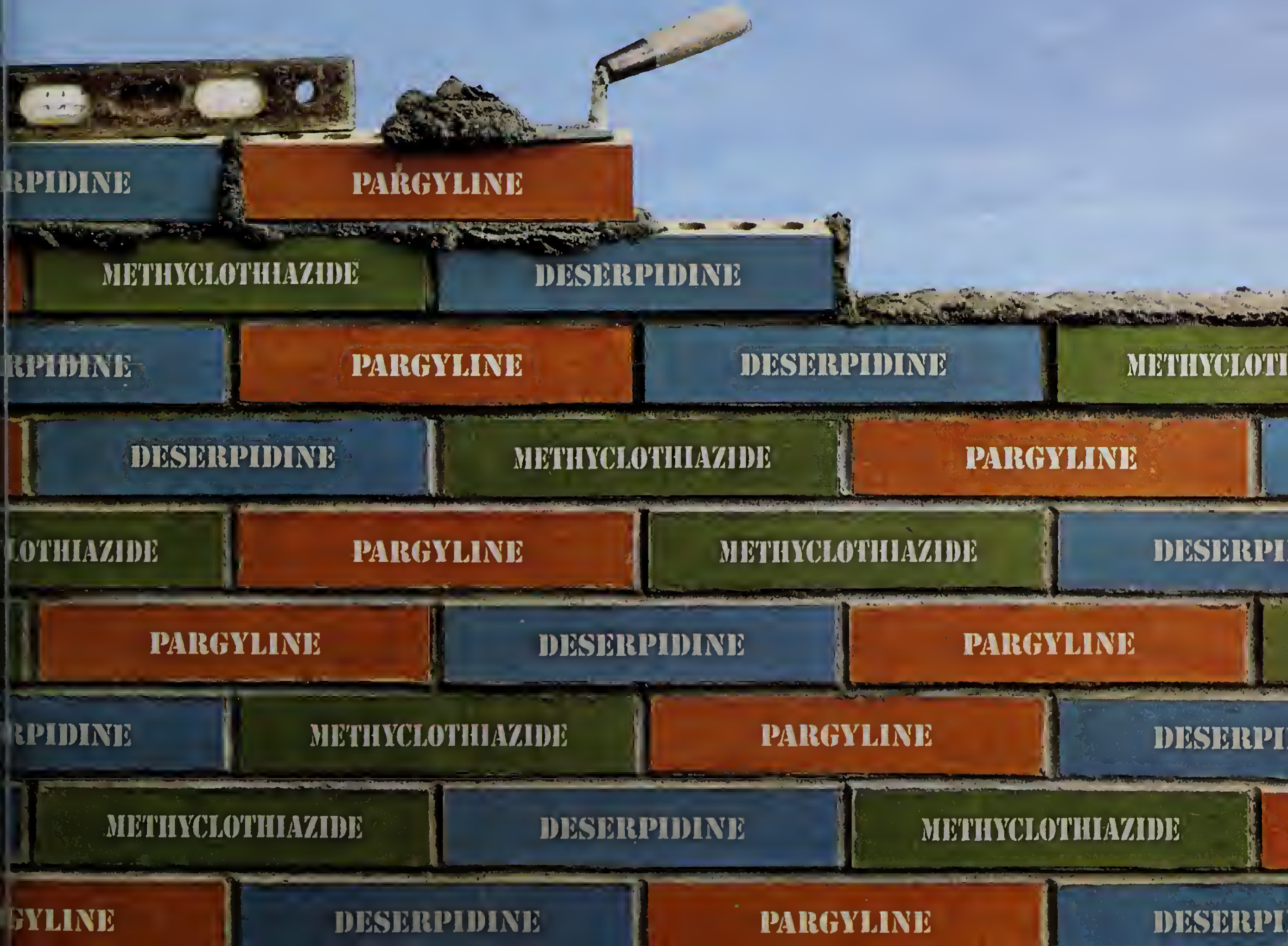
The two-day program will be devoted to exploring the implications of increased longevity for medicine, society, and the dignity of many in the urban setting. All sessions will be held at the McGregor Memorial Conference Center on the WSU campus.

Speakers also will include: William D. Bechill, Commissioner, Administration on Aging, Department of Health, Education and Welfare; Solomon Axelrod, M.D., School of Public Health, University of Michigan; Justice Theodore Souris, Michigan Supreme Court; Robert N. Butler, M.D., research psychiatrist at Washington University School of Medicine, and Walter M. Beattie, Jr., dean, School of Social Work, Syracuse University.

A complete program can be obtained from WSU Symposia Office, 5229 Cass, Detroit 48202, TE 3-1400.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension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Enduron: (methyclothiazide) A basic building block for mild hypertensives

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Tablets (Grooved)
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METHYCLO-
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Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persits for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

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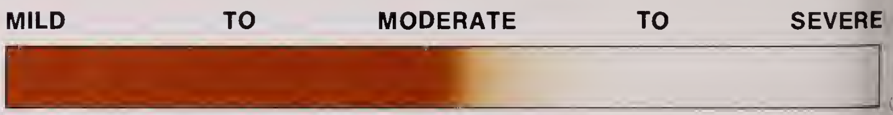
MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension

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Tablets (Grooved)
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Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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METHYCLOTHIAZIDE 5 mg. with
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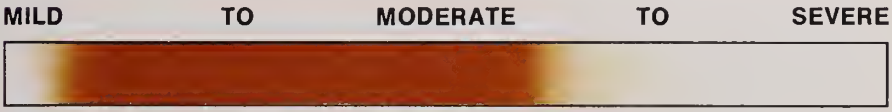
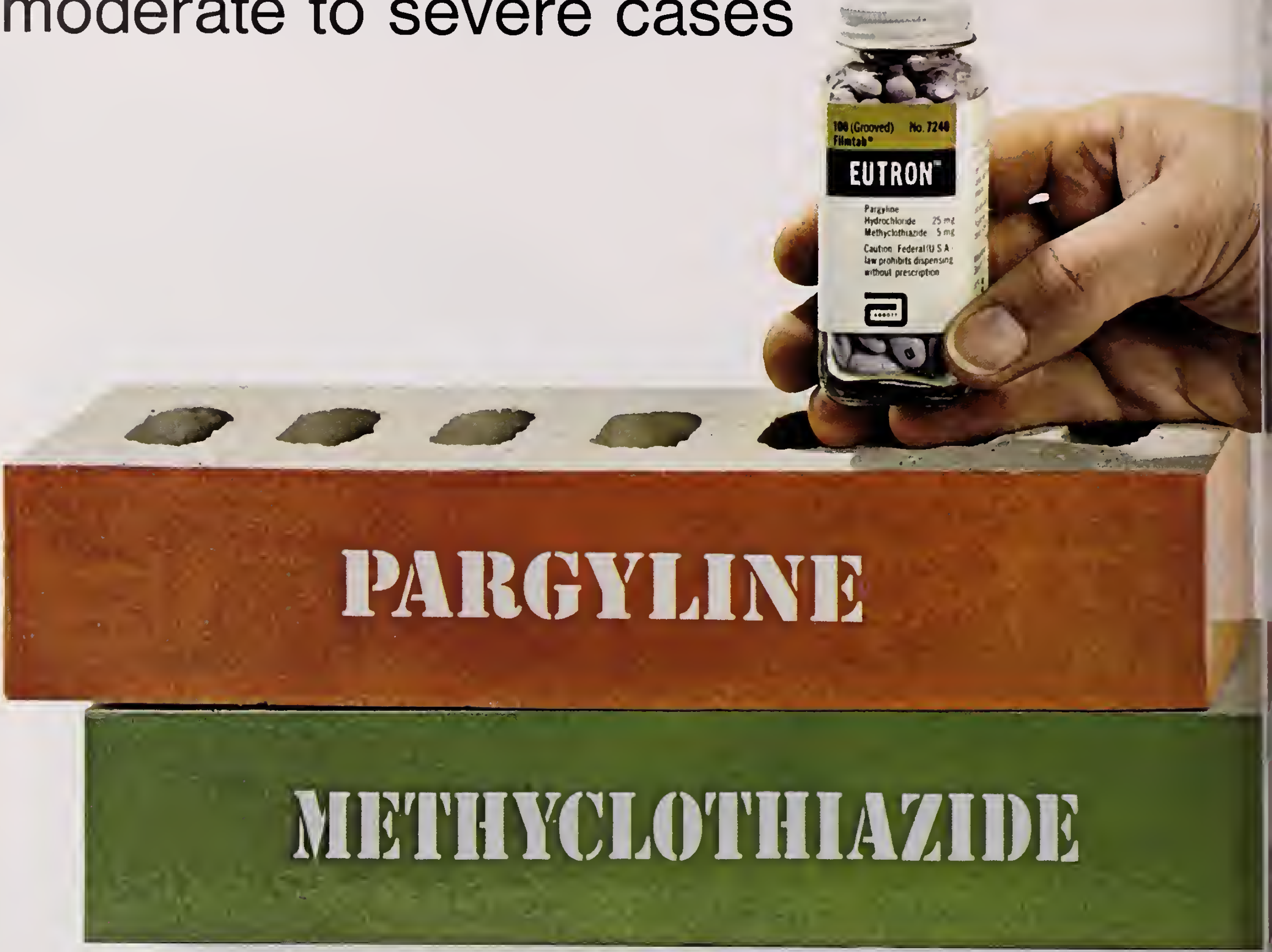


See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases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Pargyline Hydrochloride 25 mg
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Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-TRADEMARK

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

801438

ABBOTT

Reactions Sought to Suggestions of The National Advisory Commission On Health Manpower

MSMS members have several opportunities to express their reactions to the recommendations of the National Advisory Commission on Health Manpower.

Views of MSMS members can be routed through the MSMS delegates to the AMA and through the MSMS Committee on Governmental Medical Care Programs and MSMS Education Liaison Committee to The MSMS Council and thus to the AMA.

Opinions also are invited by the MSMS Publication Committee for use in *Michigan Medicine*. "Our journal serves as a sounding board for our members and letters are invited for the monthly 'Mailbag' feature," explains Brooker L. Masters, M.D., Fremont, Chairman of the Publication Committee.

The Michigan delegates to the AMA Convention and the others at Houston approved the report from the AMA Board of Trustees re the National Advisory Commission on Health Manpower Report.

THE AMA BOARD OBSERVATIONS, in part, declared "The 'Report of the National Advisory Commission on Health Manpower' reflects much of the serious attention given to the evolving needs of health care long recognized, studied and implemented by the American Medical Association and other professional groups in the health fields.

"The Report will receive the intensive study of the various expert groups within AMA and reports on their recommendations will be issued as soon as they can be developed properly. There appear to be some areas in which modifications will be necessary to assure attaining objectives sought for advancement of health care for all citizens."

The 15-member Commission, in its report to President Johnson, commented on many aspects of medical school, foreign doctors, financing of medical education, paramedical personnel, etc.

The Commission, headed by J. Irwin Miller, chairman of the Cummins Engine Co., Columbus, Indiana, was set up in May, 1966, by President Johnson to recommend ways to meet health manpower needs. Five physicians signed the report, including Dwight Wilbur, M.D., AMA President-Elect.

THE COMMISSION MEMBERS agreed that tackling the problem of manpower, alone, would not cure present ills.

". . . If additional personnel are employed in the present manner and within the present patterns and systems of care, they will not avert, or even perhaps alleviate, the crisis," the Commission said.

"Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in costs and in numbers of health personnel."

The AMA Board of Trustees, in its report to the Houston Convention, in part said, "The Commission appears to recognize the needs arising from the rapid growth of the public's desire for health care. This attitude is the result of increasing awareness of the great advances in medical science and techniques, and of the prolongation of life for millions into middle and advanced ages. . . ."

THE FEDERAL COMMISSION seems to direct some of its proposals at the AMA, MSMS and other medical organizations. Three of the proposals made by the Commission suggested:

". . . Professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals.

". . . Professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care.

". . . Professional societies, universities, and state governments should undertake, with federal support, studies on the development of guidelines for state licensure codes for health personnel."

Several of these suggestions were considered recently during the discussions at the three MSMS regional leadership conferences at Traverse City, Grand Rapids, and Birmingham.

SEVERAL OF THE recommendations under study by the AMA, the MSMS Education Liaison Committee and others deal with medical students. The Commission report states:

". . . The federal government should make available to any medical student loans to cover the full costs of tuition and living expenses during formal professional education. The student should be able to choose between repaying the loan from earnings over a period of years or giving two years of his time to approved national service apart from Selective Service obligations.

". . . The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates."

The Commission Report offers several proposals related to medical schools:

". . . Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality.

". . . The federal government should give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals."

AMONG THE OTHER Commission proposals of special interest to MSMS and its component medical societies are these:

". . . At a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U.S. medical schools.

". . . Programs for health care of the disadvantaged should be given highest priority and made available wherever needed.

". . . Nursing should be made a more attractive profession by such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions."

The views of AMA bodies will appear in future reports as it compares the Commission's suggestions against the AMA efforts to provide high quality care to all Americans.

OAKLAND PROMOTES USE OF FILMS BY LAY GROUPS

Oakland County Medical Society continues its tradition of cooperation with the Oakland County Health Department with a donation to help the department purchase the film, "A Quarter of a Million Teenagers." This is the third film which OCMS has helped purchase for the health department.

OCMS has also recently purchased the film "Parent to Child About Sex," produced by Frederick Margolis, M.D., of Kalamazoo. The film will be available from the medical society to all interested groups on a rental basis. The society plans to establish a film library.

NEW CHAIRMEN LEADING 15 MSMS COMMITTEES

The pace of MSMS committee work is picking up these winter months. Fifteen of the committees this year have new chairmen and they face organizational jobs to move their committee study and projects ahead.

Following is the list of new MSMS committee chairmen.

County Societies — J. J. Coury, M.D., Port Huron.

Education Liaison — Milton R. Weed, M.D., Grosse Pte. Park.

Liaison with Michigan Chapter of Health Insurance Council — J. J. Coury, M.D., Port Huron.

Liaison with Michigan State Pharmaceutical Association — H. C. Hansen, M.D., Battle Creek.

Liaison with Podiatry — Wm. H. Blodgett, M.D., Detroit.

Liaison with State Bar of Michigan — O. J. Johnson, M.D., Bay City.

Alcohol and Drug Dependence — H. A. Raskin, M.D., Detroit.

Awards — C. Allen Payne, M.D., Grand Rapids.

Beaumont Memorial — B. M. Harris, M.D., Ypsilanti.

Hospital Relations — J. J. Coury, M.D., Port Huron.

Advisory of Past Officers — C. Allen Payne, M.D., Grand Rapids.

Advisory to Woman's Auxiliary — E. H. Rodda, M.D., Bay City.

Maternal Health — J. E. Harryman, M.D., Muskegon.

Scientific Radio & Television — Wm. J. Ledger, M.D., Ann Arbor.

Veneral Disease Control — F. B. Bicknell, M.D., Detroit.

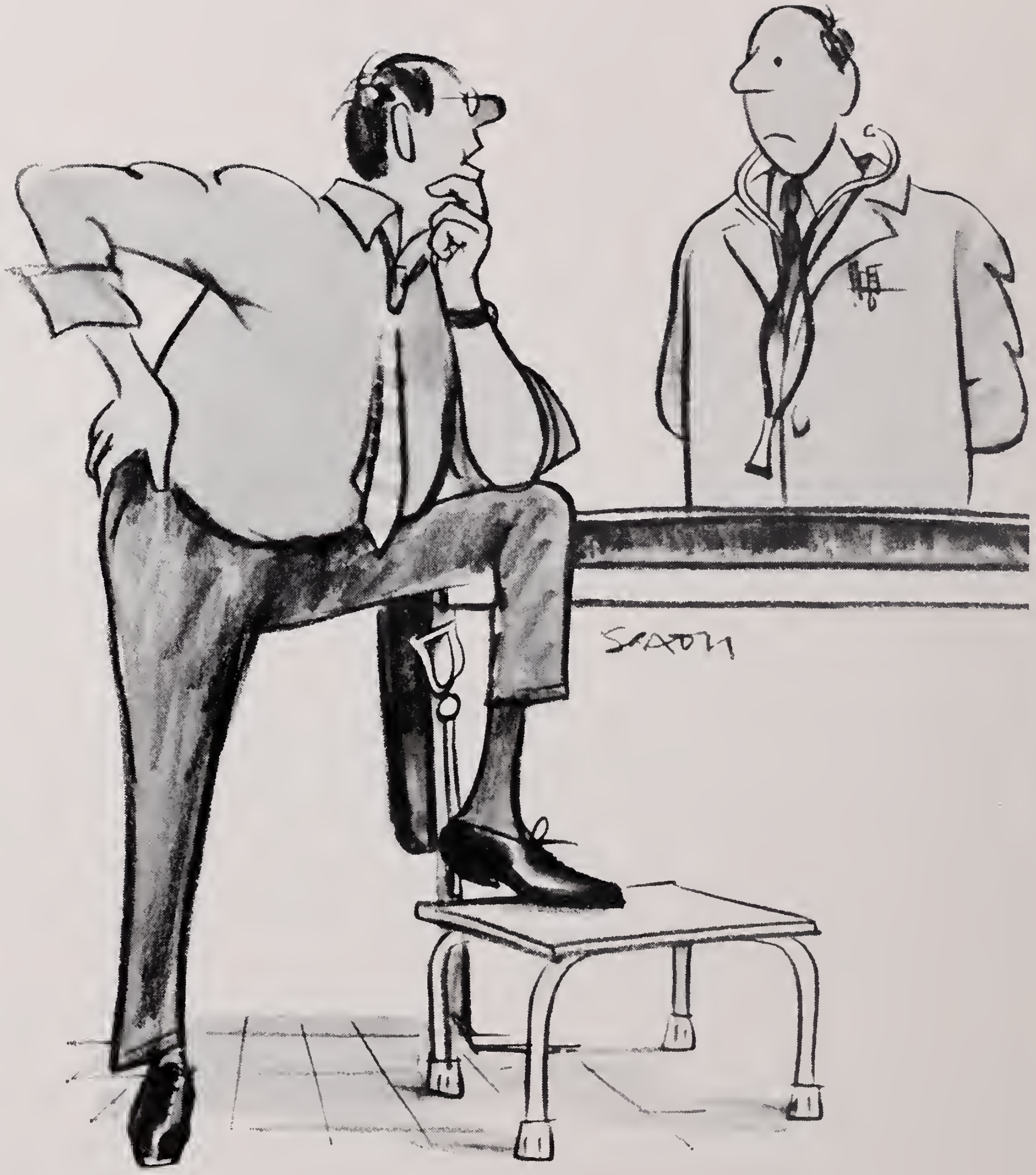
The MSMS House of Delegates committees have not been appointed to date and likely will include some other MSMS members in new positions as committee chairmen.

Pleads for Unified Voice

"The necessity for a clear and unified voice with which medicine can speak to both the public and to legislators is so clear that it needs little or no further documentation by me.

"We are in an era of medical legislation, as more and more credence is inclined to be given by many persons to the theory that health care is something to be provided by the government — just as interstate highways are built and mail is delivered by the government."

—Milford O. House, M.D.
AMA President



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

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NOVAHISTINE SINGLET

Extract of Council Minutes, Dec. 13

The Council received a report from the Michigan Delegation to the American Medical Association, Luther R. Leader, M.D., Chairman, who reviewed the action of the AMA House and the involvement of the MSMS Delegates.

Further information regarding the Treasurer's recommendations for revision of the MSMS financial management policies was received from the Treasurer and The Council approved the Treasurer's recommendations. A special session of the House of Delegates was approved, to be called prior to March 9, 1968, in order to consider the Treasurer's report as recommended by The Council.

Resolutions referred to The Council by the 1967 House of Delegates were acted upon by The Council, these being referred to the appropriate committees for implementation.

An Ad Hoc Committee to study Blue Shield was authorized by The Council in July, and the following committee members were invited to serve as of this date: Kenneth H. Johnson, M.D., Chairman, Sidney Adler, M.D., James B. Blodgett, M.D., Harold F. Falls, M.D., John R. Pedden, M.D.

President Bradley M. Harris appointed Norbert W. Scholle, M.D., Muskegon, to the Judicial Commission, filling the vacancy on the Commission due to the resignation of Carl B. Beeman, M.D.

William H. Plesscher, M.D., Lansing, was appointed as MSMS representative to the new Michigan Abortion Review Council.

Secretary Johnson reported the results of the election of the Judicial Commission: Robert H. Hamburg, M.D., Detroit, District 1; Sherman E. Andrews, M.D., Kalamazoo, District 5; W. H. Huron, M.D., Iron Mountain, District 7.

The Finance Committee recommended adoption of a budget for the fiscal year 1967-68 and commended the MSMS staff for managing expenditures for the 1966-67 budget within 1% of the proposed budget.

The Council authorized a task force composed of chairman of MSMS scientific committees to develop a possible education program for doctors and the public regarding smoking and health.

The Council reviewed committee reports from the Committee on Professional Insurance Plans, the Committee on Mental Health, the Committee on Legal Affairs, the Committee on Maternal Health, the Committee on Alcoholism and Drug Addiction, the Committee on Postgraduate Medical Education.

Clarify Questions About Osteopaths as Associate Members

MSMS Council Chairman Robert J. Mason, M.D., has written an explanatory letter to component medical societies to clarify possible questions about the election of osteopaths to associate membership.

The 1967 MSMS House of Delegates at its recent meeting in Grand Rapids approved Resolution 39 which states that osteopathic physicians may be associate members of a component society. The resolution also encourages component medical societies to offer associate membership to local osteopathic physicians on an individual basis.

A number of county medical societies are considering osteopths, who practice scientific medicine, as possible associate members.

Doctor Mason reports that "the MSMS Legal Counsel" has advised that osteopaths are eligible for election to associate membership of a component society on an individual basis, providing that he or she qualifies under Chapter 2, Section 3 (a) of the MSMS Bylaws which says, 'Any person not a member of the medical profession but engaged in scientific or professional pursuits the principles and ethics of which are consonant with those of this Society.'

"Any osteopathic association member of a component society may become an associate member of MSMS upon recommendation of a component society and election by the House of Delegates, as was done in September, 1967."

Doctor Mason also has explained that "any osteopathic associate member shall not pay dues to MSMS and shall not have the right to vote or to hold office in MSMS or his component society. A component society may require an associate member to pay local dues out of which the $6.00 subscription fee shall be paid to the State Society for *Michigan Medicine*."

Recalling MSMS Years Of Effective Service . . .

Following are some quotations from various years of the impressive MSMS service record:

1941-42

"The MSMS Medical Preparedness Committee was active in encouraging the procurement of 800 medical officers. Approximately 200 Michigan doctors joined the armed forces in 1940-41."

1930-31

"The MSMS Cancer Commission held its first meeting and decided to make a survey of the facilities for the diagnosis and treatment of cancer in each county."

1959-60

"Work on the new MSMS headquarters in East Lansing continued during the early months of 1960 and the staff moved from 606 Townsend to 120 West Saginaw in April, 1960."

(The above quotations are from A Century of Service in Medicine, the excellent history of MSMS written by MSMS Historian Wm. J. Stapleton, Jr., M.D., for the MSMS Centennial. Copies of the book are still available at cost. Send a check for $2.00 to the Michigan State Medical Society, 120 West Saginaw, East Lansing 48823.)

MEOO DIRECTOR VOICES HIS VIEWS — SEE PAGE 214

Want to understand cities and poverty and stress better?

The article quoting the views of MEOO Director Wm. R. Ford, on Page 214, will help.

Many speakers in Michigan this year have called attention to the problems of cities. Some of the views of Mr. Ford were supported in Detroit when Richard Prindle, M.D., Assistant Surgeon General of HEW, spoke to a WSU Centennial symposium. In part, he said, "If we continue to produce cities — or maintain cities — in which tension and stress, insults to physical and mental health are common, people will explode again and again in riots and destruction.

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SOCIO-ECON

HEW Official Cites Many Problems Facing Sprawling Megalopolis

Our nation desperately needs community leaders, universities and others to bring the urban revolution under control.

So declared Philip R. Lee, MD, Assistant Secretary to Health and Scientific Affairs, US Department of Health, Education, and Welfare, in his address at a recent Wayne State University Centennial symposium.

In part, Mr. Lee declared:

"We must learn to mold megalopolis to our own ends and to society's ends — to restore and preserve the sense of community identity and responsibility without which no society can long endure."

"The national government," he said, "looks to the people to offer their own resources of imagination, effort and brains in a mutual effort to find the solutions which we know we must have."

THE NEW FREEDOMS of automobile, super highway, telephone, nuclear power, etc., he said present new problems. He described the immense and sprawling megalopolis as "not truly a city but an unstructured mass with no government, no official spokesman, no self-consciousness, no sense of total community."

Air pollution and waste disposal, he suggested, are two of the concerns that no city, county or state government can solve.

Doctor Lee told the WSU symposium that, "Surely we want and need healthy communities, but we have a great many sick ones. Of course, we wish our communities to be coherent, but they appear instead to be becoming diffuse, unstructured, and impersonal.

"We see its symptoms, some of which are obvious and painful. The decay of the central cities, the summer riots, crises in urban transportation, the flight to the suburbs, air and water pollution, poverty, crime and ill-health all offer evidence of major social upheaval.

"However, these are only symptoms; they are not the revolution itself. We cannot treat them piecemeal; we must first understand the great underlying forces of which they are the obvious products."

DOCTOR LEE EXPRESSED his opinion that, "we must be concerned more about human spirit than geography. Basic to the problems is the person's own consciousness of the community around him and the role he himself plays in that community.

The personal problems today, Doctor Lee says, include these:

"Does he know his neighbors?

"Does he know where to go when he is ill?

"Does he know on whom to rely when he is in trouble?

"Does he belong to a coherent social unit?

"Does he know that he is a necessary part of the community — in fact, does he take the trouble to vote?

"Will it surprise him if he is asked to help in a worthy community cause?"

SOME OF THE COMMENTS by Doctor Lee about the city today will especially interest the Detroit Metropolitan physicians.

In part, he said:

"We must concede that the American city today has gross defects.

"It does not fully employ our technical, scientific or economic capabilities.

"It does not exemplify our most highly honored civic ideals.

"It does not inspire the best that individual men and women can contribute to community life.

"It does not provide suitable environments for the full range of human activity for all sectors of our population.

"It does not have the means to insure its orderly growth and renewal.

"It does not possess resources adequate to cope with any long-sustained interruption of its energy supply, food or services."

IN HIS COMMENTS aimed at the universities, Doctor Lee declared, "It is a primary task of our great institutes of higher education to envision and help plan our cities of the future, to study them as they are now, and to discover the ways by which their defects can be corrected.

"Surely the university must change as it reacts to the times, but no change can reduce the university's value to the Nation as a whole, or the responsibility of the university to provide intellectual leadership."

"Almost Endless" List Of Factors Complicate Health Work in Cities

What factors affect the work of physicians to improve health care in the big cities?

James A. Lee, HEW official, in his recent address at a WSU Centennial symposium, cited some of the problems of the big cities. In part, he said:

"We lose more than 24 of every 1,000 infants born alive in the United States — a record far poorer than that of many countries far less affluent than ours. And infant mortality is twice as high for the non-white as for the white child.

"Chronic illness, including cancer and heart disease, is far from being conquered.

"We do far too little in the provision of family planning services for the estimated 5 million American women who need this assistance.

"By 1970, our population will be about 209 million — and yet we are far from capable of providing for our present population of some 200 million.

"Almost 34 million people are living in poverty today in the United States, many millions of them in big-city slums.

"More than 3 million substandard housing units are occupied by underprivileged American families.

"Only about 100 of the 3,000 counties in the United States have developed coordinated community planning for their older citizens.

"Many public institutions caring for juvenile delinquents are operating below standard because of obsolescence or overcrowding.

"Our big cities are being strangled by their own traffic, and we are far behind in the development of mass transit facilities.

"Pollution in rivers, lakes and other waterways is steadily increasing. Almost half of the United States population drinks water which does not meet even minimal standards of purity.

"This nation is so rich that it throws away countless tons of waste each year — and we are far from learning what to do with it. The result: gross pollution of the air, the water, and the land.

"The list is almost endless. When we add the problems of alcoholism, drug addiction, crime, bigotry, the revolt of youth, the limited education of the underprivileged, the shortage of medical and educational manpower, mental illness and mental retardation, the physical and emotional ailments which afflict so many of our children, it becomes painfully clear that we are facing no easy task."

Consumer Price Index Up Slightly for Detroit

The most recent statistics from the Bureau of Labor Statistics reveal a slight increase in the Detroit Consumer Price Index according to the current issue of the *MSU Economic Review* report of business conditions in Michigan. The Review continues:

"The Index stands at 115.5, up 2.6 percent from a year ago. Goods and services which could have been purchased for $10 in the period 1957-59, now cost $11.55.

"Health and recreation prices rose by 4.8 percent during 1966-67. Their percentage increase 1957-59 and since last year has been greater than any of the other major groupings making up the index for all items. Within the health and recreation group, the index for medical expenses is the highest, presently at 147.0 and showed an increase of 6.7 percent during last year.

"A recent press release from the Bureau of Labor Statistics said that although most food categories showed small advances in prices, cereals and bakery products increased 1.3 percent because of an increase in the cost of flour. Prices of fresh fruits and vegetables rose 0.8 percent from September to October."

CONSUMER PRICE INDEX FOR DETROIT

Group	**October, 1967 (1957-59 = 100)**	**Percent change from**	
		Sept. 1967	**Oct. 1966**
All Items	115.5	+0.2	+2.6
Food	114.7	+0.2	+1.1
Housing	109.7	+0.2	+2.8
Apparel and Upkeep	114.7	+0.3	+2.0
Transportation	114.8	+0.5	+2.1
Health and Recreation	128.2	-0-	+4.8

Source: Bureau of Labor Statistics

Help can be weeks away for a painful shoulder.

Except with Butazolidin® alka.

If it doesn't work in a week, forget it.

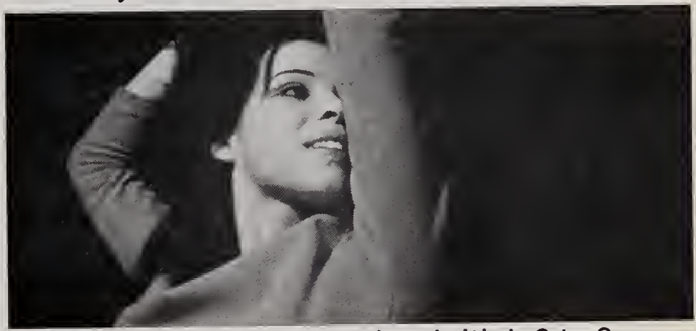
ut don't forget this about Butazolidin alka

ontraindications: Edema; danger of cardiac ecompensation; history or symptoms of pep- ulcer; renal, hepatic or cardiac damage; story of drug allergy; history of blood dys- asia. The drug should not be given when the atient is senile or when other potent drugs are ven concurrently. Large doses of Butazolidin ka are contraindicated in glaucoma.

arning: If coumarin-type anticoagulants are ven simultaneously, watch for excessive in- ease in prothrombin time. Instances of evere bleeding have occurred. Pyrazole com- ounds may potentiate the pharmacologic ction of sulfonylurea, sulfonamide-type gents and insulin. Carefully observe patients eceiving such therapy. Use with great caution the first trimester of pregnancy.

recautions: Before prescribing, carefully elect patients, avoiding those responsive to outine measures as well as contraindicated atients. Obtain a detailed history and a com- lete physical and laboratory examination, in- luding a blood count. The patient should not xceed recommended dosage, should be losely supervised and should be warned to iscontinue the drug and report immediately if ever, sore throat, or mouth lesions (symptoms f blood dyscrasia); sudden weight gain (water etention); skin reactions; black or tarry stools r other evidence of intestinal hemorrhage ccur. Make regular blood counts. Discontinue e drug immediately and institute counter- easures if the white count changes signifi- antly, granulocytes decrease, or immature orms appear. Use greater care in the elderly nd in hypertensives.

dverse Reactions: The most common are ausea, edema and drug rash. Swelling of the nkles or face may be minimized by withhold- g dietary salt, reduction in dosage or use of iuretics. In elderly patients and in those with ypertension the drug should be discontinued ith the appearance of edema. The drug has een associated with peptic ulcer and may re- ctivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: one week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. 6309-V(B)R2

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COMING EVENTS

March 6—The Council, MSMS Headquarters, East Lansing

March 13-14—Annual meeting of the Michigan Academy of General Practice, Sheraton-Cadillac Hotel, Detroit

March 26-27—Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 1—47th Annual Beaumont Lecture by Jose M. Delgado, M.D., at Wayne State Medical Society Headquarters, Detroit, 8 p.m.

April 17—The Council, MSMS Headquarters, East Lansing

April 22-25—Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

April 23-28—17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

May 1—Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8—Mental Health Week

May 4—Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 8-10—Michigan Public Health Association, Inc., Annual Conference, Jack Tar Hotel, Lansing

May 10-11—Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 15—Annual Muscle Symposium Wayne County Medical Society, Detroit

May 18—Kresge Eye Institute Clinic Day, Detroit

May 18-19—Pediatric Clinic Days

June 5—The Council, MSMS Headquarters, East Lansing

July 18-20—The Council, Grand Hotel, Mackinac Island

Aug. 21—The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24—MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 25-26-27—MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Nov. 11-15—American Public Health Association Annual Conference, Detroit

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anticostive* hematinic

Your Prescription Blank

Dear Lederle
Send me samples
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(Mail to Department 150
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*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
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Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
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Folic Acid	0.05 mg
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HISTORY OF WAYNE STATE UNIVERSITY PUBLISHED

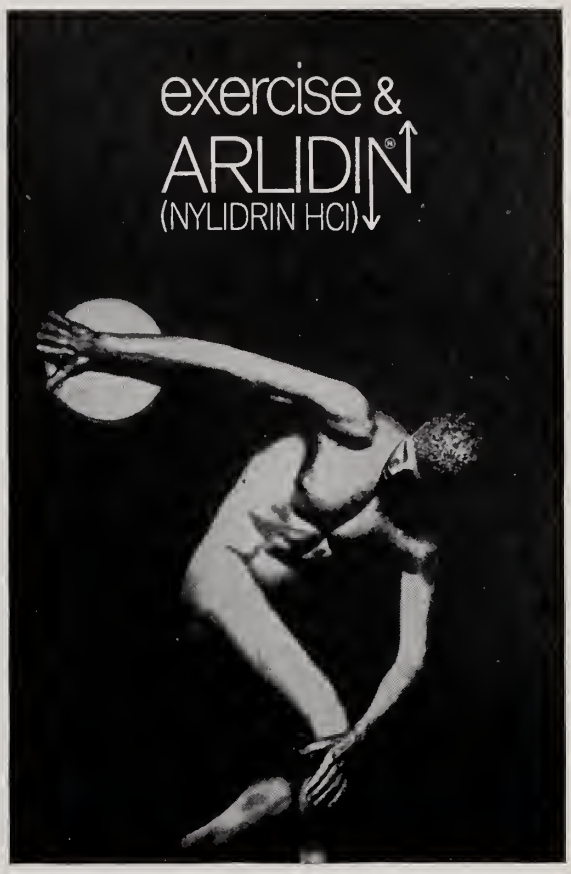
After 11 years of research, interviews, and letter writing, Leslie L. Hanawalt, Ph.D., WSU historian, has completed the history of Wayne State University.

Available now from WSU Press, the 512 page book, *A Place of Light,* was originally commissioned by Clarence B. Hilberry, former president of the university, as a Centennial year project.

The seed from which the present, sprawling university grew was the Detroit Medical College, built on Woodward Avenue after the Civil War. Founders of the Medical College were five bearded medics, young men ranging in age from 29-35: Theodore A. McGraw; Samuel P. Duffield; David O. Farrand; George P. Andrews; and Edward W. Jenks.

The history of the University is told in terms of topics rather than strict chronology. Physicians will especially be interested in the long chapter on the history of the Medical School.

Doctor Hanawalt, a former English professor, has written *A Place of Light* with facility and precision. The book will be enjoyed by any reader interested in the history of Detroit or the history of medicine.



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* 1904 - 1967

Michigan Doctors Describe Vietnam Experiences as Volunteers

BY PETER HOHEISEL
OF THE MSMS STAFF

The 1967 MSMS House of Delegates voted that the several Michigan physicians who "at great personal sacrifice have volunteered their services to the civilians of South Vietnam . . . be given highest praise and commendation for their outstanding work in this valuable portion of the international health activity of the medical profession in Michigan."

Recognizing that many other Michigan physicians have served in Vietnam and other parts of the world under various programs, the resolution commended the nine men who have been involved in the "Volunteer Physicians for Vietnam" program sponsored by the American Medical Association.

THE PRAISE GIVEN these men stands as a symbol of the admiration which the medical profession feels toward all its members who have given of themselves in various parts of the world.

The reasons why physicians, at financial loss and personal hardship, have served in Vietnam vary from "to be where the action is" and "because I'm sick of treating disability cases, and want to see some real disease for a change" to the simple statement "I want to help."

While the motivation is complex, the deed is simple: These men have given of their skill, their time, and indeed of themselves, to a suffering people who desperately need and appreciate their help.

SOME MEN ENCOUNTERED difficulty with supplies and had inadequate facilities; others had little or no difficulty in this area. All found the AMA program well organized and efficient. All found the experience in Vietnam tremendously rewarding, both personally and professionally. Not one of them regrets it.

Following is what these men have to say about their experience:

Robert T. Baugh, M.D., Detroit, General Practice, Long-Xuyen, Aug. 1 - Oct. 1, 1967

"I feel very privileged to have been a member of the volunteer physicians who have participated in Project Vietnam. What little we gave of ourselves to the people was more than repaid by the immense gratitude shown us by the South Vietnamese.

"Even before the onset of hostile activities in Vietnam, the South Vietnamese lived and died with rampant communicable diseases that in most parts of the world had become well controlled decades previously. Diseases ranged from bubonic

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Scholten in Vietnam Now; Elliott Just Returned

Presently in Vietnam is Roger A. Scholten, M.D., a Kalamazoo surgeon. Doctor Scholten will serve in Vietnam until March 14.

Recently returned from a provincial hospital near Saigon is J. Colin Elliott, M.D., of Buchanan.

Michigan Medicine will carry comments by these men in a later issue.

plague, cholera, diphtheria, typhoid, tetanus, leprosy and yaws to raging tuberculosis of entire families.

"Virus infections varied from the well known, such as typhus and poliomyelitis to the obscure such as hemorrhagic fever with its mortality of over 90%. Parasitic infestations were nearly all types, to amebiasis. And then, as was so often the case, multiple system involvements with multiple afflictions and diseases. The life expectancy is said to be 35 years, and nearly 50% of children die shortly before their 5th birthday. This was easy to believe after a short time there.

"Add to this misery the fact that bodily injuries, such as fractures, were often not adequately treated, if at all, because of lack of medical facilities and personnel, to people with acute abdominal conditions who simply died without the benefits of available surgery.

"Now, compound this need of medical care and treatment with the results of war injuries, (there have been varying medical statistics concerning the ratio of civilian casualties versus military, but 10 civilians to 1 military in many regions has been often stated).

"I believe the American physician has a real responsibility to the people of South Vietnam, to the very young and the very old and the women who seem so often to be in the middle without the relatively good medical care afforded to the South Vietnamese man in the military, because of what the hostilities have caused to their minds, their hearts, and their bodies. Their resultant insecurity, with its attendant deep fear of most strangers, was reborn and nourished through 25 years of nearly constant war beginning with the Japanese during World War II. Their fear was understandable, and their humility and desire to trust us, often with their lives, could only make us very proud to be American physicians and grateful to our colleagues who had come before us to prove to these people we wished only to help them.

"For the physician who serves, there can be no greater reward than the knowledge that he has helped ease the lonely pain and intense suffering of individuals who, had he not taken a relatively short time from his private practice in this country, may very well have died, died simply because had he not been there at the time, there would have been no physician available. Such knowledge makes it very difficult for the physician to leave these people, and, such lasting thoughts thereafter rededicates the physician to responsibilities vested in him.

"I saw disease there which I never see here."

"What little we gave of ourselves to the people was more than repaid by the immense gratitude shown us by the South Vietnamese."

"For the physician who serves, there can be no greater reward than the knowledge that he has helped ease the sufferings of individuals who may very well have died had he not been there at the time."

"By caring, we might change these peoples' hatred into friendship, their fears into understanding, for the language of medicine is international."

"I remember one Viet Cong boy I treated who had been shot through both legs. He thought he would be tortured and killed. He was surprised that he was not. He then planned to defect from the Viet Cong."

"The double bonus here, of course, is winning the people over from the Viet Cong which in essence is why we are there."

"American medicine, because of its superior science and pragmatic approach, is sought by people throughout the world."

BAUGH

CAUMARTIN

Hugh T. Caumartin, M.D., Saginaw, Radiology, Binh Dan Hospital in Saigon, April 6-June 8, 1966

"I guess, in every part of the world, God has produced particular beauty. In Vietnam the sun and the air combine to produce a tropical panorama of color. I have seen beauty of nature before, in many parts of the world, but never to this lavish extent. Good and evil sometimes travel part way on the same road but, in Vietnam, they seem to meet — the ultimate in intrinsic beauty with the ultimate in ugliness, a union of heaven and hell on earth. A contradiction: God's intent so obvious in fertile beauty; man's desecration so obvious in reality.

"Vietnam is a country where the average life expectancy is about 35 years, where half the children never reach their fifth birthday. In addition to death from diseases, the situation is aggravated by thousands of civilian war casualties, people who are innocent victims, caught in the cross-fire of ideologies they don't understand.

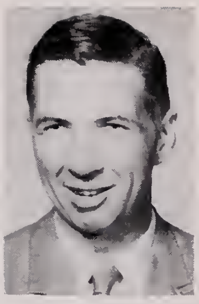
"This is a war that is not merely a matter of seizing hills and bridges. By mere battle, there is little hope of victory. Even our professional military men say we can't win this war without helping the people so that they will trust us. And in this regard, in medicine, we have a distinct advantage. By caring, we might change these peoples' hatred into friendship, their fears into understanding. For the language of medicine is international. And to give of one's self to those in need makes the parable of the good Samaritan a vital force. Surely America, at its zenith and still ascending, must export its total spirit of democracy to the needy of the world.

"Understanding — unless America can lead the South Vietnamese to a desire for their *own* liberation, then military victory means nothing.

"And so we physicians of America face a challenge.

"And besides, it is a meaningful experience to become totally immersed in the practice of medicine, to enjoy a certain amount of adventure and a feeling of 'being where the action is.' "

Relatives of the native patients perform most of the non-professional medical care in the orthopedic ward at Can Tho. The visitors were all over — because of their strong family ties.



GRADY

NEERKEN

Joseph A. Grady, M.D., Detroit
Surgery, Rach Gia, Sept. 11 - Nov. 11, 1967

"The experience is beyond comprehension. The feeling of personal satisfaction is one of the greatest you can achieve.

"There is a great need for general and orthopaedic surgeons; a volume of reconstructive work to be done that is just waiting. I was at a 500-bed hospital, about 150 of these were surgical beds with one general surgeon myself, and one orthopaedic surgeon.

"We had both acute and chronic diseases to be treated. Most of our work was with acute disease with some elective. At the time I left, there was no replacement for me in sight.

"We in medicine have an opportunity to get out and see the world as well as give service. When you work as a physician in a country, you get to know the people in a much deeper way than you would on a cook's tour.

"The AMA has organized the Volunteer Physician Program for Vietnam remarkably well. At each stop we met someone there to instruct and guide us. It is the best organized program I have ever worked with, everything clicked. When I got to Rach Gia everything was set up and ready to go. It was great, I highly recommend it."

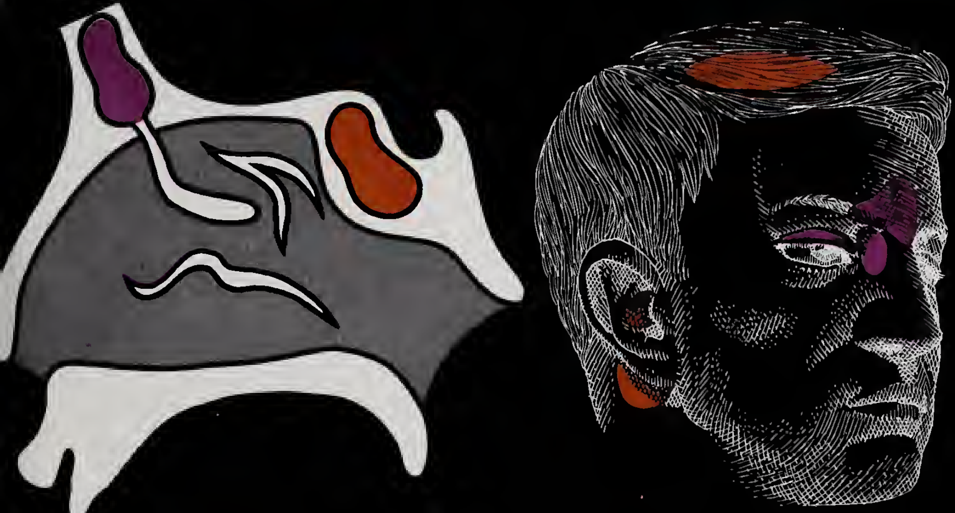
A. J. Neerken, M.D., Kalamazoo, Thoracic
Surgery, Nha Trang, Sept. 23 - Nov. 23, 1967

"It was a fantastic experience. Primarily seeing how people live in a different society and how medicine is practiced in another country.

"At first the people were suspicious, it took them time to get to trust you. Many people had first been to the old Chinese doctors who practice things like cupping, ocupuncture, plasters, pinching, and various potions of herbs and barks. By

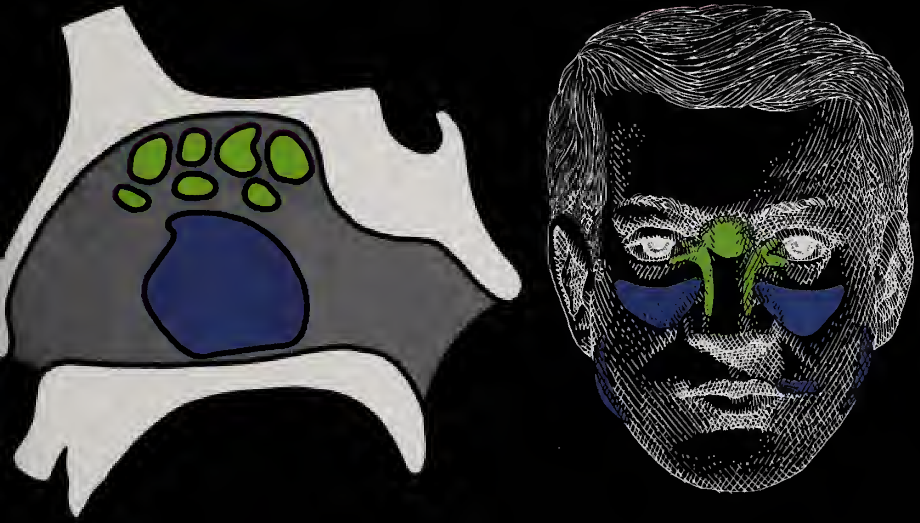
Continued on Page 257

Sources of sinus headache

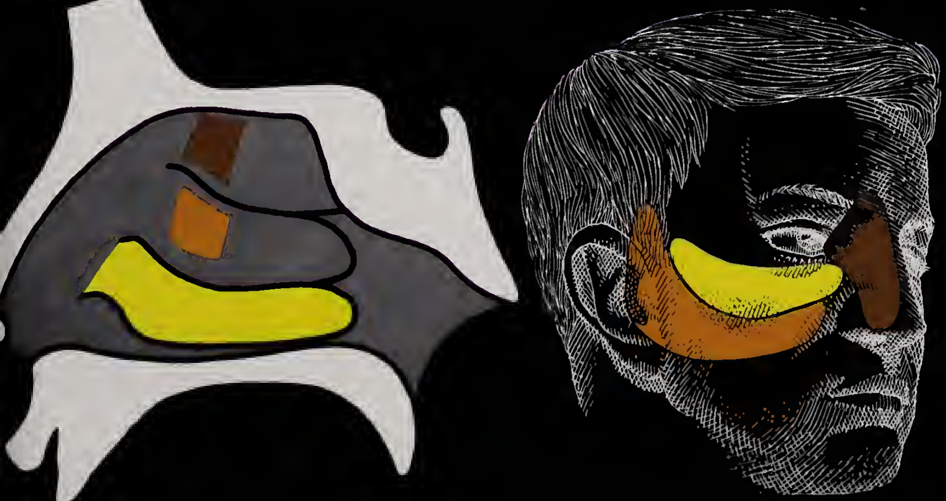


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids. SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

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FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

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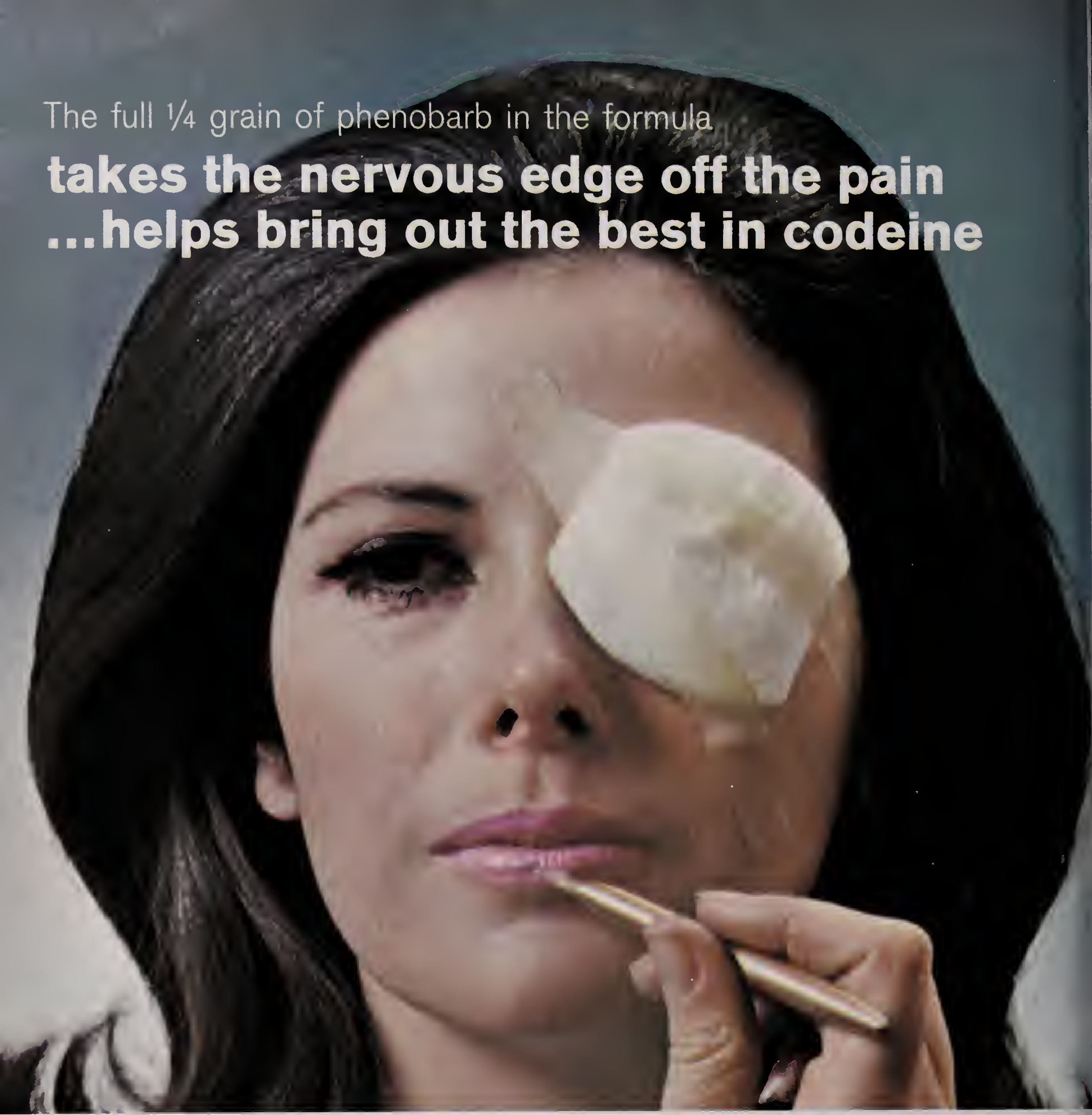
The full ¼ grain of phenobarb in the formula
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Each capsule contains:

Phenobarbital (¼ gr.)	16.2 mg.
(Warning: may be habit forming)	
Aspirin (2½ gr.)	162.0 mg.
Phenacetin (3 gr.)	194.0 mg.
Hyoscyamine sulfate	0.031 mg.
Codeine phosphate	¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)	

Contraindications: Hypersensitivity to any ingredient.
Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.
Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

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New York, N.Y. 10016

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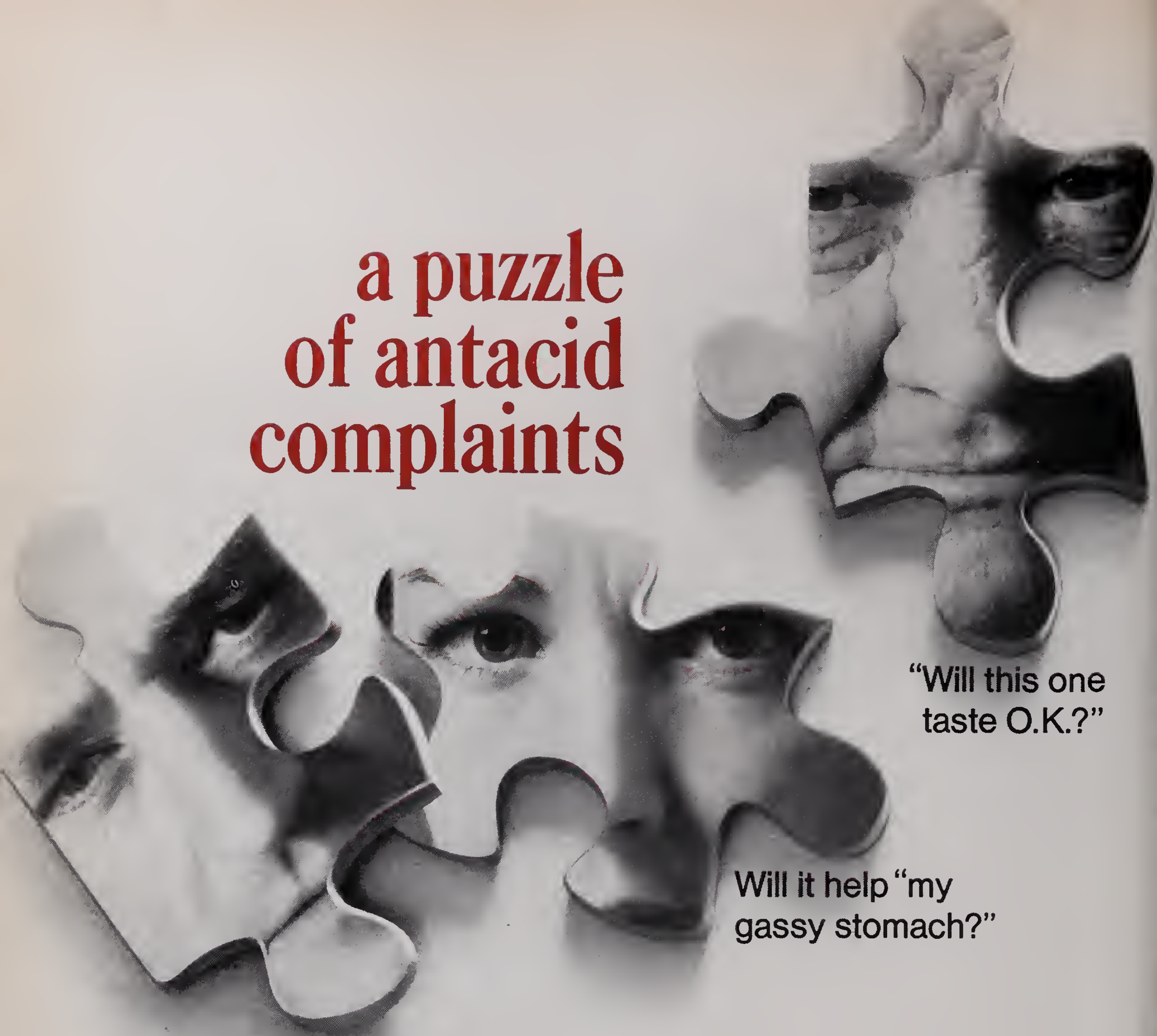
NASAL SPRAY

relieves nasal symptoms on contact



"Will this one
taste O.K.?"
Will it help "my
gassy stomach?"
"Will it stop the pain?"

a puzzle
of antacid
complaints

Mylanta®
aluminum and magnesium hydroxide *plus* simethicone

a solution
to peptic ulcer
distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

the time that people came to us they were often far along in disease.

"In general we were in good shape with supplies. Our major problem seemed to be the water supply.

"I remember one Viet Cong boy I treated who had been shot through both legs, he thought he would be tortured and killed. He was surprised that he was not. He then planned to defect from the Viet Cong.

"I never felt in danger because everyone knew who we were. The Viet Cong knew that if they or their family were hurt, we would take care of them. In fact, I was tipped off a couple of times when something was about to happen.

"I would highly recommend the AMA program to any physician who is interested."

Lambertus Mulder, M.D., Muskegon General Practice and Trauma, Baclieu, May 1 - July 1, 1966

"South Vietnam medical work is an exciting change of pace and location for two months that excells even a pleasure tour of the Greek Isles.

"Why? Because the people are so appreciative, so different in outlook and character. Because the Viet Cong under my care did show, day by day, a gradual awareness of my care for them and a change in attitude from surliness and fear to warmth and welcome. Because the Buddhist Monks always were pleasant and eager to talk with their U.S. friend, no matter the Christian faith he spread.

"I recall an eight-hour canal boat trip: helping a family during a fire on their sampan, the careful caution of the 12 machine gunners who rode along side and fanned out ahead of us on shore.

"Language is a challenge that excites one when you begin to make yourself understood: When you walk streets far off the beaten path and surprise the villagers with a Caucasian face but a Vietnamese hello. But you are more surprised than they when you cannot find a street in town where someone does not know you and call out 'Cho ong Bacsi' — doctor.

"I gained a lack of fear in speaking Vietnamese at a party given in our honor. I gained the friendship of the local Hospital Chief, as well as many, many other people in Baclieu, my station town.

"What did I gain from an attack of Dengue? Nothing!

"Back home our citizens want to know what is going on, with our medical work; with the people we obtain contact with the average Vietnamese citizen — language barriers or no.

"For these reasons I would encourage other physicians to come along with us to Vietnam."

MULDER

SULFRIDGE

A father carries his wounded daughter into the Provincial Hospital at Can Tho.

Hugh L. Sulfridge, M.D., Saginaw, Orthopaedic Surgery, Can Tho, April 7 - June 7, 1966

"Much of my life in Can Tho was quite similar to what one had in his resident training in a busy city hospital. In my instance it was like the work that I did in the Detroit Receiving Hospital. We worked as a team. There was a tremendous esprit de corps, and all of us regretted the termination of our two months stay.

"Had it been planned such that we could have stayed longer, I am sure every one of us would have enjoyed a much longer tour. Unfortunately, for the average civilian doctor in private practice it is almost prohibitive for him to extend his tour much longer than two months without a great deal of sacrifice and a great deal of planning in the future.

"A run-down of the first day will give some idea of the type of cases we were seeing and this seemed to hold true more or less for the entire two months of my stay in Can Tho.

"A six-year-old boy, right hand partially blown away, hand grenade.

"Twenty-four-year old female, left femur, compound fracture, penetrating wound abdomen, rifle.

"A twenty-year-old male, compound comminuted fracture of the femur, three young adults, compound comminuted fractures of the tibia and femur, shrapnel and gunshot.

"Twenty-year-old male, right face and neck gunshot, partially blown away compound comminuted fracture of mandible and maxilla, rifle.

"Eighteen-year-old male, right hand and right elbow compound comminuted fractures, rifle.

"In addition to this there were seven gunshot wounds or penetrating wounds, abdomen requiring lapcratomies.

"The highest number we acquired in one day was thirty-four, all civilians, mainly women and children, wives of a home defense unit and their children caught in a Viet Cong mortar attack.

"We are definitely winning friends and influencing people. I do not wish to imply that the American is especially loved by the Vietnamese. He is respected and he is liked because he is lending a hand, I think in a Christian way. The double bonus here, of course, is winning the people over from the Viet Cong which in essence is why we are there. So whether we put the buggy before the horse or the horse before the buggy makes little difference here.

"We are there in a missionary way, in a Christian way, and we are there to win the Vietnamese away from the Viet Cong. I feel extremely privileged to have been a part of this project."

Alfred B. Swanson, M.D., Grand Rapids
Orthopaedic Surgery, Canto-Danang-Saigon, Total of four South Vietnam trips 1962-64-66-67

"I do not consider my service in South Vietnam as a great personal sacrifice and of no greater personal risk, than many of the things that we do. I think the reason for our going other than the fact that we enjoy the trip, the people and the work, is that we feel concerned about what happens over there.

"I think we also feel, and increasingly so after repeated visits, that the professionals who go into these under-developed countries and provide a needed service, are America's best diplomats. The humanitarian good that is done, is certainly of prime concern. However, the secondary effects of winning a people away from the attractions of Communism, are just as great.

"The people in Asia need something to aspire to. They need the inspiration of American skilled volunteers who are interested in helping them to change their lives to the good. America is filled with dedicated, skilled people from all walks of life who could meet this challenge. Our problem is to recruit and mobilize them and provide them with the equipment with which they need to work.

"The medical problems are so intertwined with the social and economic deprivement existing in the emerging nations, that medicine can and should be the spearhead in their rehabilitation.

"American medicine, because of its superior science and pragmatic approach, is sought by people throughout the world. It is the easiest thing that we have to sell. American medicine, therefore, has a responsibility and American doctors have an opportunity, for enriching their lives with a wonderful experience of giving."

SWANSON

WADE

Want to Volunteer For Vietnam? Details Available from AMA

MSMS members interested in obtaining the details about the AMA Volunteers for Vietnam program may write to:

Volunteer Physicians for Vietnam
American Medical Association
535 N. Dearborn St.
Chicago, Illinois 60610

The International Health Committee of MSMS is currently studying various aspects of overseas medical work. One of the main concerns of the Comittee is to promote an increase of medical aid to the civilian population of South Vietnam. The Committee feels that the current U.S. budget for medical aid to civilians is very inadequate.

Franklin V. Wade, M.D., Flint
Surgery, Phu Vinh, July 15 - Sept. 18, 1967

"It is very difficult to make an accurate statement as to what I may, or may not, have gained

One by one
the family's downed
Because the
G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

from my experience in Vietnam. The major personal gain was that of personal satisfaction in having been able to provide some measure of surgical care for these very deserving and appreciative people.

"It is evident that much of the necessary medical help that these people receive would not be possible if it were not for American physicians in these provincial areas. In addition, it was very gratifying to be able to assist the American military physicians who are doing such a splendid job in this effort.

"Although contact with the Vietnamese physicians is certainly limited, I think that the accumulated influence of American physicians in Vietnam is bound to be beneficial to the Vietnamese physicians.

"Finally, I think that the effort of the American physician in Vietnam tends to cancel out some of the devastating efforts of the war and indicate to the Vietnamese people that a positive effort is being made to improve their lot, instead of the inherent destructiveness of warfare. Each individual physician is, in effect, an ambassador in a limited way; and, as such, is bound to create a measure of good will."

BEAR

Edward S. Bear, M.D., Formerly of Detroit, Working now toward Ph.D. in Pharmacology at Columbia; Danang, July 10 - Sept. 1, 1967

"I think it was a valuable experience medically and personally. You don't see psychosomatic problems, only the very sick get to see a doctor. I saw disease there which I never see here. Also it was an opportunity to see medicine in another country.

"The AMA is doing a good job. John Miller, an AMA administrator in Saigon did a fantastic job getting doctors in and out.

"There is a great need for internists in Danang. Two of us had 90 patients with TB. The only difficulty was an occasional problem with facilities and supplies."

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She relies
on your
contraceptive
advice

She can expect to continue Oracon for years

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16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

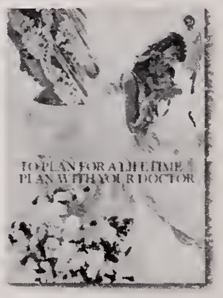
observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

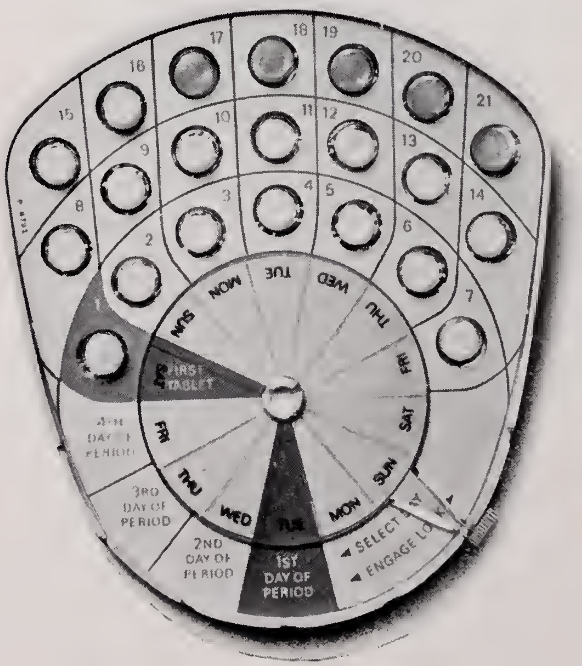
Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.



The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.



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Mead Johnson
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Health Council Helps Place Nine More in State

Recent placements by the M.D. Placement Service of the Michigan Health Council have included the following: Andre Michaud, M.D., Jackson; Antanasio Fajardo, M.D., Oakwood Hospital, Detroit; Hugh McCullough, M.D., Sturgis; Wilbur VanderYacht, M.D., Saline; James O. Shaw, M.D., Bay City, (Locum Tenens); Phillip Fry, M.D., Muskegon; Raymond Bernreuter, Saline; Michael Sabbagh, M.D., St. Clair; and Jacques Hochglaube, M.D., Lansing.

SAYS COMPUTERS GIVEN WRONG TASK TO DO

Men are too conservative to be efficient information processors, according to an engineering psychologist at the University of Michigan.

"Men fail to become as certain of conclusions as the evidence in their possession justifies," explains Professor Ward Edwards, head of the U-M Engineering Laboratory.

"Understanding and simplifying a problem takes all the wisdom and intuition that experts can bring to it. But actually making the decision is trivial — it can easily be done by a desk calculator or a digital computer," Edwards said.

"Men should process the information as it comes into the system and pass it on to computers that make the decisions. Unfortunately, all such systems in existence now do it the wrong way around; computers process the information and men make the decisions," concluded Edwards.

TEXAS AUTHORITY COMING FOR SINAI CONFERENCE

Col. Haskell Gruber, U.S.A.F., D.C., chief of the orthodontic section at the Wilford Hall Hospital at Lackland, Texas, Air Force Base, will speak on "Early Management of the Cleft Palate Infant" March 6 at Sinai Hospital in Detroit.

Sponsored by the Sinai Hospital Cleft Lip and Cleft Palate Center in conjunction with the Orthodontia Section, the talk will begin at 2:00 PM at the Paul and Helen Zuckerman Auditorium and Conference Center. Program for the afternoon is as follows: 1. Cleft Palate Team; 2. Diagnosis, Prognosis, and Treatment Plan for the Cleft Palate Infant; 3. Pre-Surgical Maxillary Orthopedics; 4. Bone Grafting to the Maxillary Alveolar Arch — When and Why; 5. Combined Cheiloplasty and Bone Grafting in One Procedure; and 6. Secondary Cases — Orthodontics, Bone Grafting — When and Why.

All members of MSMS and their guests are invited.

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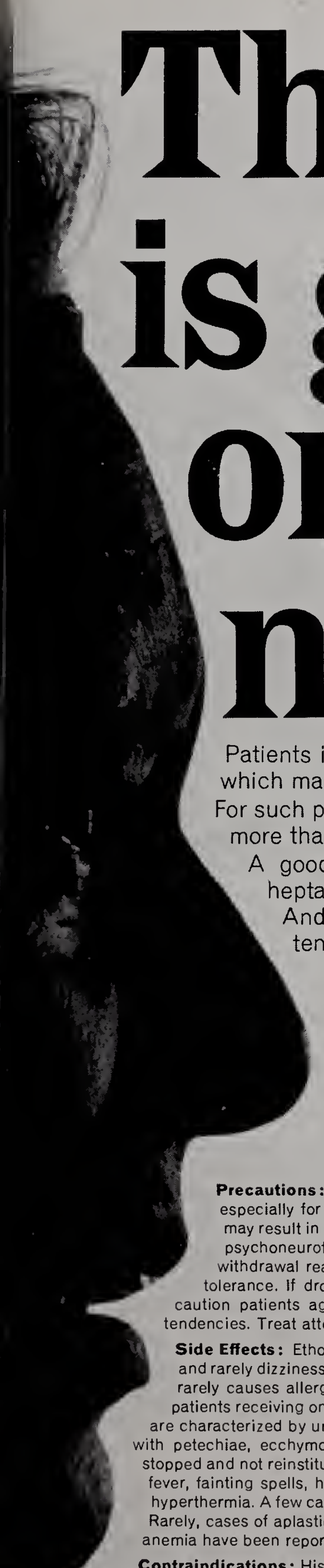

This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS
(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy.

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

VIEWPOINTS

Everybody's Planning

Particularly since the start of the Kennedy administration, a tremendous impetus has been given from Washington, D.C., to federally-funded health programs characterized at their inception by a new concept — "planning." As Dean Wm. Hubbard, M.D., would put it: "Planning has become a very sexy word" in the middle-to-lower echelons of federal department programmers.

First and most visably, mental health burst upon the scene as an area where there was said to have been "far too little planning." Hard on its heels came public health with special emphasis on facilities, manpower and education. "Planning" soon came to be encouraged as an initial activity indispensable to the implementation of *any* new health program — from air pollution control to automobile safety standards to Medicare.

WITHIN THE LAST couple of years a whole new generation of semi-professional, sub-level bureaucrats has been born and reached adolescence — the "planners." Former statisticians, economists, political scientists, and just plain welfare department clerks have found new status — and possible opportunity — as "planners."

The next logical development has been perfectly predictable. It has been the move to now "bring order out of chaos," to undertake "comprehensive" effort. Naturally, this must come about through a comprehensive plan, created by comprehensive planners.

Now federal law 89-749 *demands* comprehensive planning. It is a law with the sharpest teeth of all. Unless a given health project meshes into the comprehensive plan, there will be no federal money for it! (It follows that comprehensive health planners are very important people indeed. In fact if there was a single comprehensive planner in any state with this federal law behind him he could be a czar!).

Michigan, to implement this federal law, already *has* a Comprehensive Health Planning Council — but this Council yet has no executive director, no staff, and no Advisory Committee (the law states that the Advisory Committee must be composed of *more consumers* of service than providers of service). So far, Michigan has set up a five-man group, all of them state government executives. Soon this group will have all the appurtenances.

WHO WILL SUBSTANTIALLY influence the make-up, the deliberations, and the final decisions of this embryo Council?

There has been a fantastic proliferation of "planning groups" within Michigan in the immediate past. One almost expects to confront a new one with each passing day.

Of course, substantial and professionally-oriented groups such as the W. K. Kellogg Foundation's Hospital Division, Blue Cross and Blue Shield, the Michigan Health Council and the Michigan State Medical Society have "planned" for years. But of late, due to the intensified federal impetus and the implied financial threat to specific categorical interests (heart, tuberculosis, cancer, etc.) the planning field has been moved in to *en masse*.

"PLANNING" ACTIVITIES in mental health produced, about three years ago, a foot-high pile of published recommendations of the Department of Mental Health. Most of these have been augmented (or duplicated) by the Mental Health Society and other private groups. About contemporary with this early activity — the first waves of a flood — was the broadgauge "McNerny Report" and its successors out of various Governor-appointed bodies.

Now groups operating under federal grants, and coalitions of categorical health organizations, are bidding to preempt the "planning" field. Most of these bill themselves as "consumer-oriented" but "professionally advised," and they are developing and releasing studies and recommendations by the ream. And their studies are current ones.

There is a "Committee of Forty," tied to the School of Public Health, University of Michigan. There is an even newer "Governmental and Voluntary Executive Forum," which stands ready to advise Michigan's Governor on comprehensive planning. The Greater Detroit Area Hospital Council, the Michigan Welfare League, the Michigan Department of Social Services — to name but a few — are all busily planning.

Before long — in fact, momentarily — Michigan's Comprehensive Health Planning Council will flesh out and go into business. And from which quarter will it seek major guidance? Will it turn to the health professions? These groups have been increasingly accused lately of having long dominated official health agencies — as a part of an obvious campaign to insinuate that the result has been a poor system of providing health care. Will the new Council turn to new groups advertising themselves as "consumer public oriented" and possessed of current surveys, opinions and directions?

The State Comprehensive Health Planning Council *should* turn to such an organization as the Michigan Health Council, which is representative of most health groups, independent and itself citizen-oriented — but will it? The answer, at the moment, can only be "maybe."

The initiative floats in the air. It's up for grabs and everybody's grabbing.

Auxiliary Boosts AMA-ERF

BY MRS. W. G. GAMBLE, JR.,
PRESIDENT, WOMAN'S AUXILIARY

One of the official projects of the Woman's Auxiliary to the Michigan State Medical Society and of the AMA Auxiliary is raising money to support AMA-ERF, American Medical Association Education and Research Foundation. AMA-ERF is the only fund-raising project of the state and national auxiliaries, and money contributed to it supports three programs: Funds for Medical Schools (specific medical school may be designated), Loan Guarantee Fund, and the Institute for Biomedical Research. Doctor, if you are planning a contribution to your medical school, please consider making it through the Auxiliary's AMA-ERF fund.

This year Mrs. Fleming Barbour of Flint, State AMA-ERF Chairman, has vowed that the Auxiliary will surpass its previous contributions. This aim constitutes a major goal, for last year Michigan's donation ranked third among states whose membership is greater than 3,000.

In 1967, Michigan's Auxiliary increased its contribution to AMA-ERF by $4,723.09, making the total contribution an impressive $23,406.78. To illustrate further Michigan's outstanding work, the Macomb County Medical Auxiliary won a National County Achievement Award for the largest contribution to AMA-ERF in its category of membership.

Whereas donations comprised approximately one-fourth of Michigan's total contribution, 75 percent of the money was raised by selling Christmas cards, stationery, charms, playing cards, stuffed animals, etc., and by sponsoring teas, dinners, auctions, and fashion shows. Money is also raised by the use of Memorial Cards, in tribute to a deceased person, and In Appreciation Cards for medical courtesy extended to a physician's family. In Appreciation Cards are used for contributing to the medical school of the physician who treated a physician's family.

AMA-ERF is a major project of the Auxiliary, but there are other projects of equal importance, to which the Auxiliary devotes equal effort. Therefore, Doctor, urge your wife to join the Woman's Auxiliary to your county medical society, and if she is a member, encourage her to devote greater effort to AMA-ERF and the other excellent Auxiliary projects. In addition to the personal satisfaction she will gain from the many worthy activities, you and the profession of medicine will benefit from her dedicated participation!

AMA Restates Purposes

BY LUTHER R. LEADER, M.D.
CHAIRMAN, MSMS DELEGATION TO AMA

We in MSMS — and in our county medical societies, specialty groups, the AMA, et al., — have worked for years in the interest of the public.

We have often felt that the general public, politicians, educators, bureaucrats and others have not been aware of our dedicated efforts to advance health care for everyone. Letters-to-the-editor, platform comments, magazine articles often have blistered the physician and his professional societies without knowing the facts.

Personally, I am glad that the AMA House of Delegates in Houston adopted a positive 11-point document to place the medical organization solid behind continuing efforts to stimulate progress in all aspects of health care in America.

THE EXPANDED STATEMENT of purposes and responsibilities of the AMA declares in detail the broad initiative which is ours to advance health care for everyone.

The statement declares that it is the responsibility of the AMA, as the representative of the medical profession, to continue to foster the advancement of medical science and the health of the American people and to discharge that responsibility through the following means:

1. BY ENCOURAGING THE advancement of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. BY creating incentives to attract increasing

numbers of capable people into medicine and the other health-care professions.

3. BY advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. BY DEVELOPING TECHNIQUES and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facilities — physicians' offices, hospitals, laboratories, clinics and others — as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. BY MAINTAINING the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

I would urge individual physicians and certainly our component societies to help promote and interpret this new statement of the AMA purposes. The original purpose more than a century ago, "to promote the science and art of medicine and the betterment of public health" is still appropriate but the new 11-point statement will have far more meaning to the general public.

LELAND F. CARTER, M.D., WILL CHERISH HISTORY OF MSMS BY STAPLETON

The MSMS Publication Committee recently received an order and $2.00 from Leland F. Carter, M.D., Detroit, for a copy of *A Century of Service in Medicine,* the MSMS history written by Wm. J. Stapleton, Jr., M.D., our MSMS historian.

And there's a story behind Doctor Carter's request for the Stapleton book . . .

Soon after Doctor Stapleton, who reached his 91st birthday this past Christmas, set up his office on the sixth floor of the David Whitney Building in downtown Detroit in 1932, he was joined on that floor by two physicians, the Carter brothers.

John and Leland Carter set up practice together in 1934. John, who is 76, is now retired in Florida. Prior to his retirement in 1965, John Carter specialized in ear, nose, and throat, and regularly took care of Doctor Stapleton when the need arose.

Doctor Leland Carter, an ophthalmologist, is now 66. Both he and Doctor Stapleton continue their practice at the David Whitney Building.

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find it first!

Make tuberculin testing routine
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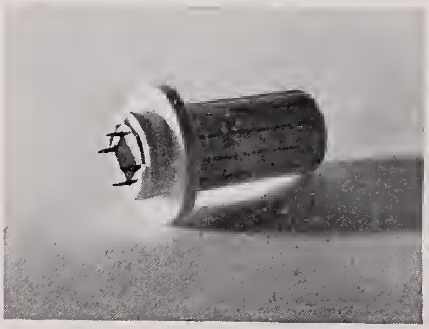

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A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

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CONTINUED: VIEWPOINTS

Pleas for MSMAS Members

BY MRS. NELDA GASPERSON, CMA, MSMAS PRESIDENT

This article is particularly directed to the doctor whose medical assistant is not a member of the medical assistants society.

Are you aware of the many advantages that membership in this society gains for your medical assistant?

Primarily this organization was formed to render honest, loyal and more efficient service to the medical profession and to the public which it serves.

The Michigan State Medical Assistants Society is comprised of 21 component societies with a total state membership, as of June, 1967, of 739 members. The American Association of Medical Assistants, 12,000 strong, from its inception 11 years ago has been endorsed and encouraged by the American Medical Association.

A resolution adopted by the American Medical Association House of Delegates in 1962 urges all physicians who have medical assistants who are eligible for membership to join and participate in American Association of Medical Assistant programs. At the annual convention of the American Medical Association in Atlantic City, Milford Rouse, M.D., newly elected president in his first report to the House of Delegates said, "Every physician owes it to himself to become acquainted with the objectives and programs of the American Association of Medical Assistants. By charter, their organization can never become a union. Its purpose is to make every doctor's assistant a more knowledgeable and efficient aide."

A NATIONAL CERTIFICATION program has been developed to aid physicians in recognizing top level aides in either the clinical or administrative fields. In order to become a certified medical assistant one must take an examination which is given annually in various testing centers. Five sections of this examination must be passed. Out of 214 applicants tested in 1967, only 74 passed the examination successfully. Eight certified medical assistants reside in Michigan.

An attempt is being made to assist schools and colleges in developing training programs and courses. At the present time, a program is underway to recruit and train medical assistants. This pilot program involves twelve colleges around the country. It is being conducted in cooperation with

Say you saw it in Michigan Medicine

the American Medical Association and the American Association of Junior Colleges.

Two days of educational programs are part of the American Association of Medical Assistants annual convention. The state convention of the Michigan State Medical Assistants Society also offers educational programs. They annually conduct an educational seminar and an Officers and Committee Chairman Workshop. These programs not only furnish educational material but stimulate fellowship and cooperation among members. Component societies have programs based on subject material from which they derive much information.

IT HAS BEEN SAID that "the medical assistant who is polite, well trained and devoted to her job is a valuable member of the health team." The contributions that this organization offers to the physician in effect are loyalty, devotion to service with the continuing educational standards of self improvement for the betterment of her physician employer.

The Michigan State Medical Assistants Society needs your encouragement and support.

State Doctors Elected To Social Health Board

Two Ann Arbor physicians have been elected to the board of directors of the American Social Health Association representing the midwest region. Elected were Harry A. Towsley, M.D., and Harold J. Magnuson, M.D., both with the University of Michigan Medical School. Lincoln B. Frazier, M.D., Marquette, was chairman of the nominating committee.

STATE BAR FOUNDATION GETS GRANT FROM OEO

Funded at $72,845 in OEO monies, the Michigan State Bar Foundation is grantee for a statewide legal services program established with the primary purpose of providing technical assistance to the State's 15 legal services programs and to communities that want to initiate programs.

The new technical assistance agency will coordinate and assist in administration of local programs whose combined budgets represent 3.8 million dollars in legal services to the disadvantaged.

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7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

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INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

MAILBAG

The Mailbag department is a forum, provided for free individual expression. Letters are published as received and given little or no editing. Responsibility for statements rests with the authors of these communications and not with this journal which strives only to protect the right of individuals to speak for themselves.

On behalf of the Washtenaw Obstetrical and Gynecological Society, I wish to refer to the comments presented by A. Stewart Kerr, Legal Counsel, Michigan State Medical Society in *Michigan Medicine,* July, 1967, pertaining to parental consent for the dispensing of contraceptive pills to minors.

Whereas we realize that there are many ramifications to this issue and that each case must be individually considered, we do wish to present a view expressed by members of this Society who deal with these problems with great frequency.

Each physician has his own rules and regulations by which he practices medicine, whether it be in the order of giving an opinion or in prescribing various medications including oral contraceptives. It is the consensus, however, that the emancipated minor is "emancipated" irrespective of her age and, therefore, in the interest of the individual patient who desires to control conception, we strongly feel that parental consent is not indicated and is not necessary under these circumstances. This girl already has received parental consent for the marriage and all that goes with it.

This is obviously a medical impression — not a legal one — but it reflects the well thought-out ideas and ideals of a group of interested persons who encounter this problem every day. We do not wish to become involved in moral, religious, or legal dialogue, but we are obligated by licensure to practice medicine with the interest of the patient foremost in our minds. To be specific, we are interested in aiding couples who wish to space pregnancies or to prevent them altogether so that they may achieve their aims. Control of conception is particularly important in teenage marriages, which are known to be particularly unstable; at least half of them ending in divorce. If married, a requirement of parental consent when it is unnecessary legally might well hamper their important aims.

George W. Morley, M.D., President
Washtenaw Obstetrical and
Gynecological Society

(Note: The proofreader changed the word "serous" to "serious" in a letter printed in the December issue. We are sorry because the error changed the context of the point being made by the author. The entire letter is reprinted below:)

In response to the viewpoint expressed by Dr. George H. Lowrey entitled "The Dangers of Adeno-tonsillectomy," I feel this "danger" can be answered in two words . . . practically none!

In this day of endotracheal anesthesia and electro-coagulation of bleeding points the procedure should cause a minimum of problems to a doctor trained in throat surgery.

As to the value of tonsillectomy and/or adenoidectomy, I would simply ask the parents of our young patients these questions:

(1) Has your child missed less school time from throat infections since the T & A?

(2) Has your child had less ear trouble since the T & A?

(3) Has your child discontinued his mouth breathing and "stuffy" speech since the T & A?

In my practice the answer to these questions is a resounding *yes*!

I know of no otolaryngologist who advocates the "family plan" or the routine scheduling before starting school. Each patient should be evaluated individually so that unnecessary surgery can be avoided.

In discussing two procedures which should be considered practically worthless, I offer these two in particular:

First, the needless allergic testing and prolonged treatment for nasal obstruction in children due to blocking adenoid tissue.

Secondly, the use of huge volumes of antibiotics administered for the child with serous otitis media. Therefore adenotonsillectomy is the wisest course of treatment in many of the ENT problems troubling the pediatric age patient.

Sincerely,
Robert D. Burton, M.D.
Chairman of ENT section MSMS 1966-1967,
Grand Rapids

winter 1968

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.

this issue: the cold in pregnancy...

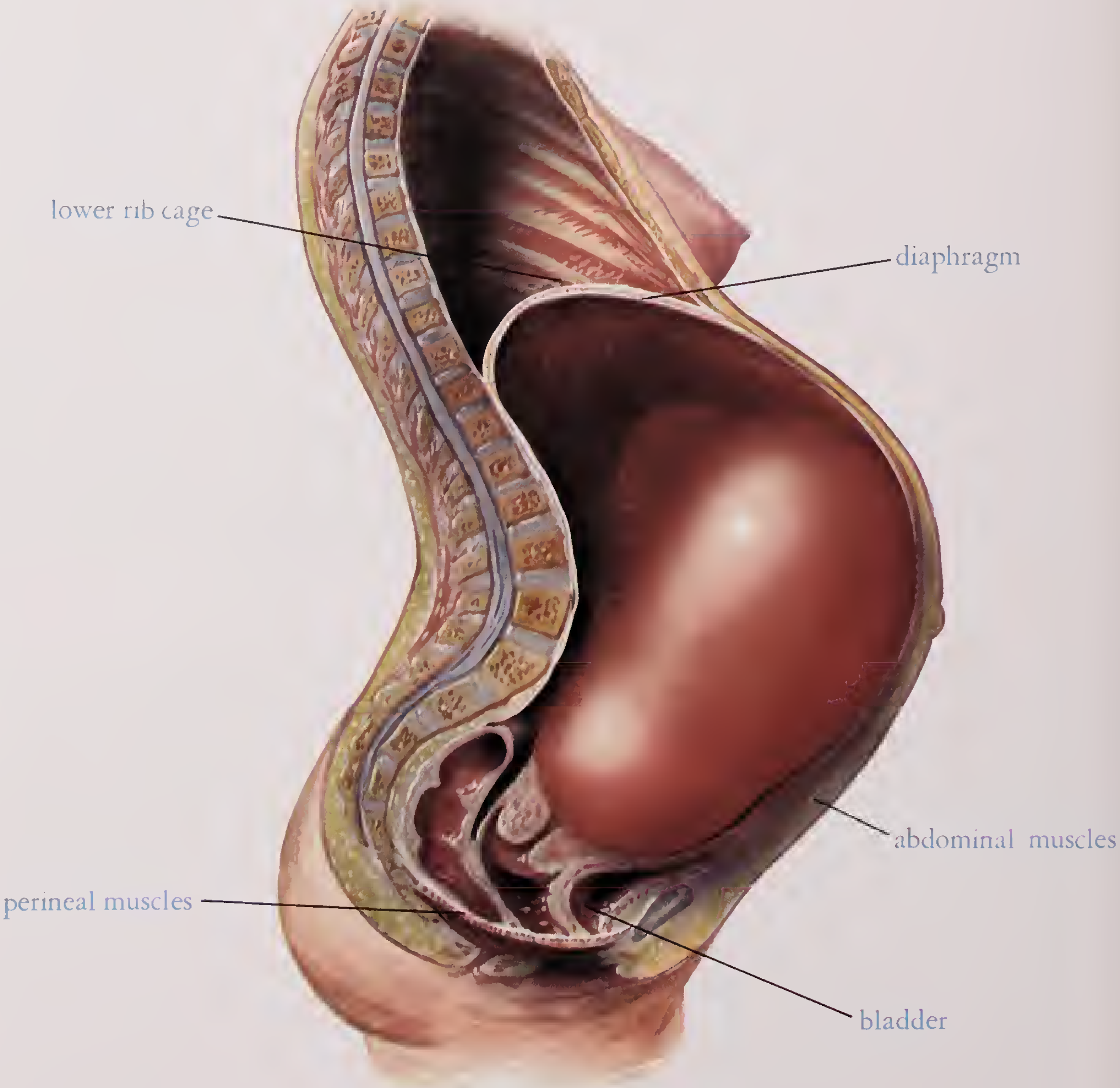
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

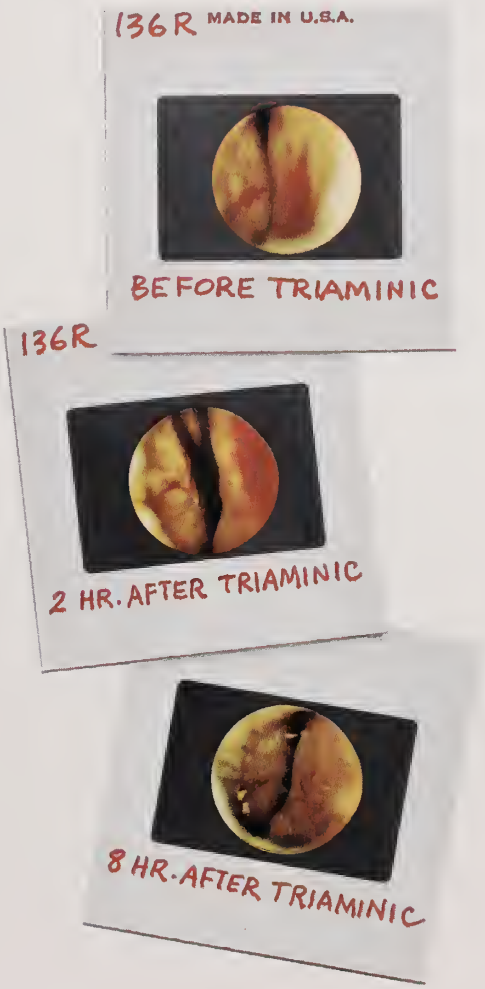
Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion…



timed to work while your patient does

A study begun in 1966 by the Department of Otolaryngology, Greater Baltimore Medical Center, has accumulated evidence that documents the effectiveness of Triaminic's timed-release action in the treatment of nasal congestion.

With its balanced formulation of an oral nasal decongestant and two antihistamines, Triaminic effected partial or complete relief in more than 82% of the 85 subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

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(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops The use of antibiotics in an uncomplicated cold i contraindicated and should be scrupulously avoided

In summary, a cold in pregnancy is more severe an longer lasting. The treatment of the symptoms wit local and systemic decongestants will make th patient more comfortable.

Apparently the cold is so common in pregnancy tha it has received very little attention in the literature References are almost non-existent and the fe which are available add little to the common knowledge, are out-dated, or are not helpful. Thus th usual bibliography is not appended.

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Tell her to get
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Pyrilamine maleate	6.25 mg.

For nasal congestion you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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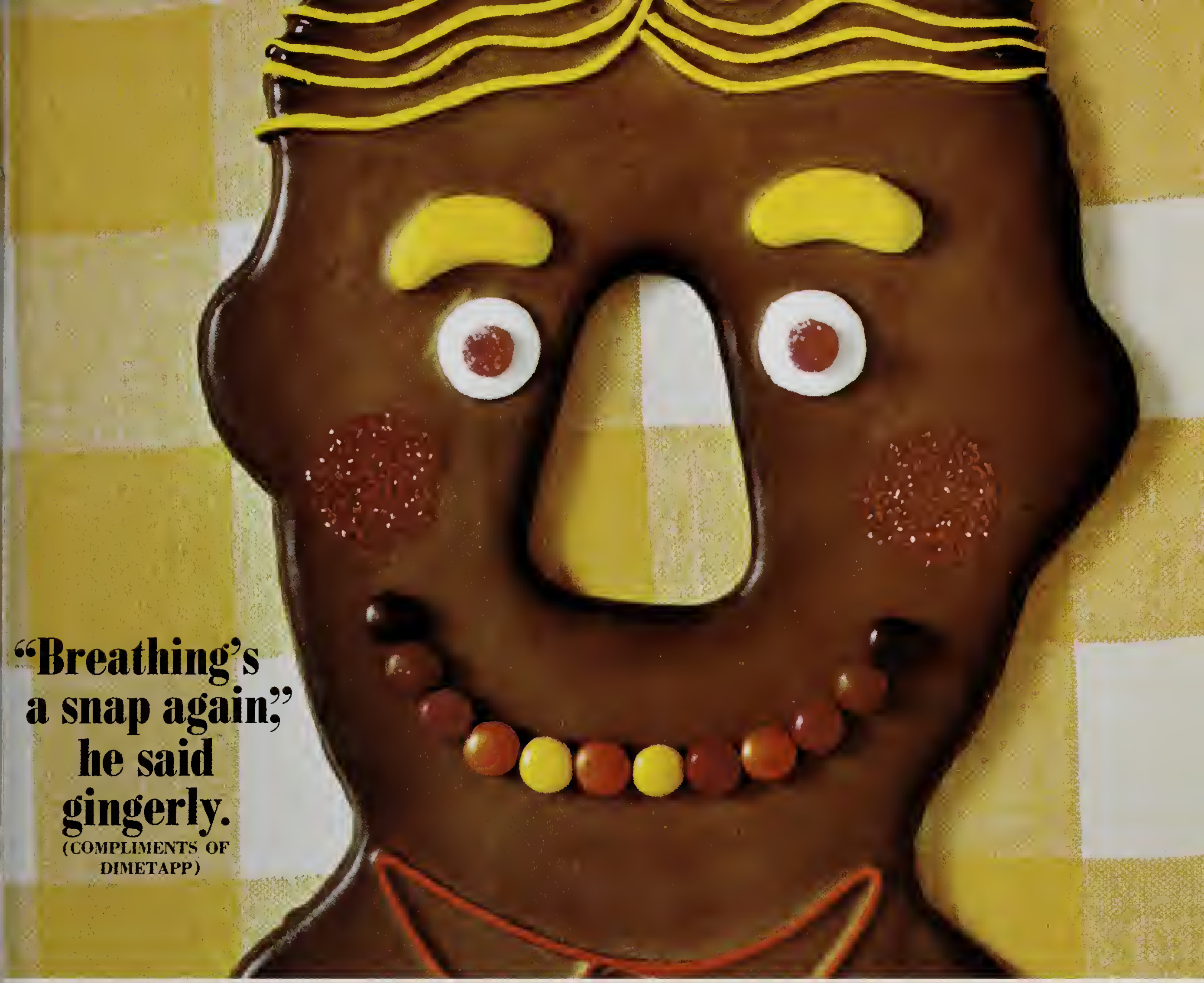
"Breathing's a snap again," he said gingerly.
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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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Dimetapp® Extentabs®

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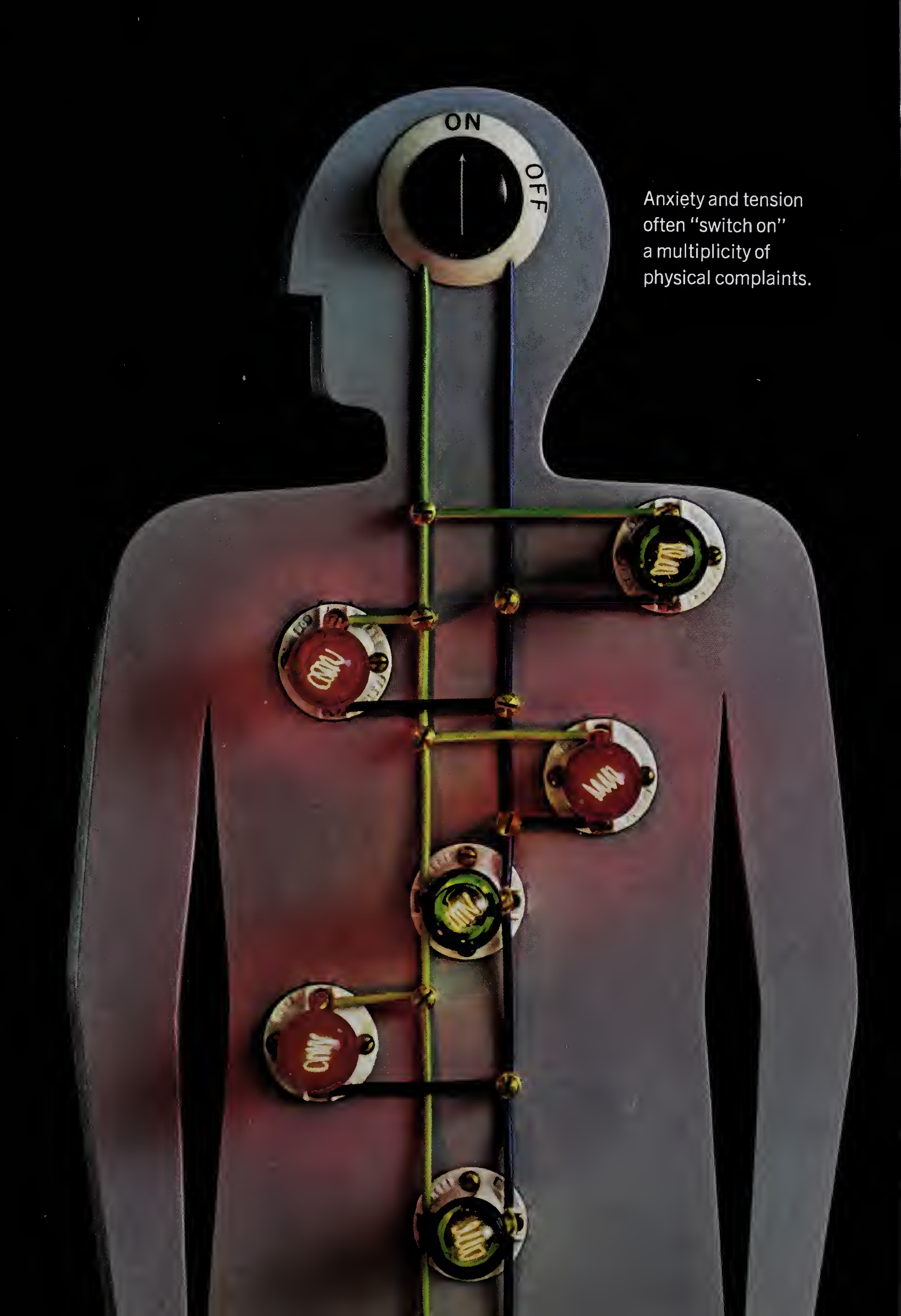
up to 10-12 hours clear breathing on one tablet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Anxiety and tension often "switch on" a multiplicity of physical complaints.

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Two salient features seem to set Tybatran somewhat apart from certain other commonly used tranquilizers.

1. Tybatran often proves more effective than meprobamate and chlordiazepoxide. In one study,[4] severe anxiety responded more effectively to tybamate than to meprobamate; in another,[8] symptom-response superiority of tybamate over chlordiazepoxide was marked at statistically significant levels of confidence.

2. Tybatran appears to be less sedating than other widely used tranquilizers. Side reactions are relatively infrequent; when they do occur, they may take the form of drowsiness, although insomnia, ataxia and other adverse effects have been reported. Nevertheless, Tybatran impresses many clinicians by its comparative lack of undesirable sedative action.[3,6,12,13] (If drowsiness or vertigo is present, activities requiring optimal alertness should be avoided.)

For patients in whom anxiety is manifested in any of a multiplicity of physical complaints, Tybatran deserves a clinical trial. These are the challenging patients, those with recurrent, persistent, ever-changing symptoms for which there is no clinical or laboratory evidence of organic disease.

Usual adult dose: one or two 250 mg. capsules 3 or 4 times daily. Adjust to suit individual requirements.

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Prescribing Information

Dosage and administration. The suggested adult dose of Tybatran (tybamate) is one or two 250 mg. capsules three or four times daily. Dosage should be adjusted to suit individual requirements. While clinical experience with Tybatran (tybamate) in children has been very limited to date, the recommended daily dosage for children 6 to 12 years old is 20 to 35 mg./kg. body weight, in three or four equally divided doses. Dosage should be adjusted to suit individual requirements. Until further clinical experience is obtained, administration of Tybatran (tybamate) to children under 6 years of age is not recommended. Daily doses larger than 3000 mg. are not recommended, although in a few instances doses in excess of this figure have been administered. Tybatran (tybamate) is also available in 350 mg. capsules, for convenience in dosage adjustment, e.g., one capsule three times daily and two at bedtime.

Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

(pronounced TYE-buh-tran)

Tybatran™
brand of tybamate

a tranquilizer with particular usefulness in functional disorders

Prescribing information continued from preceding page.

withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

Supply. Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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31 QUESTIONS PRESENTED FOR COMPONENT SOCIETIES TO STUDY, DISCUSS

What are some of the subjects which merit—and demand—the attention of the component county medical societies and MSMS?

Thirty-one questions were on the agenda for the three recent MSMS Regional Leadership Conferences. The conferences, authorized by the 1967 House of Delegates, were held at Traverse City, Grand Rapids, and Bloomfield Hills.

1. Relationship of associate membership of osteopaths in county medical societies to hospital staff membership of osteopaths.
2. What changes do doctors need in the abortion laws to permit them to do what they want to do?
3. Should sex education in the schools be liberalized?
4. Program of contacts with legislators.
5. What changes need to be made in the Medical Practice Act?
6. Quackery and cultism conferences.
7. Relationships with podiatrists, optometrists and psychologists, nurses and other paramedical personnel.
8. Planning for potential new vaccine programs (measles and mumps).
9. The effect of use of computers in hospitals on the practice of medicine.
10. The impact of foreign-trained doctors.
11. The medical care team and medical practice patterns.
12. Video tape recorders program.
13. The "care gap" and an accredited training program for continuing medical education.
14. Group practice and hospital emergency rooms.
15. Malpractice insurance and its effect on medical practice.
16. Medical assistants and their training.
17. Michigan Association of the professions (MAP) and Michigan Health Council (MHC) services and support.
18. The purposes of regional leadership conferences and opinion survey.
19. Air, water and land pollution.
20. The doctor draft.
21. Government medical care programs
    a. Medicare and Medicaid
    b. Heart, cancer, stroke
    c. Comprehensive health planning
22. Generic prescribing of drugs.

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Now Burdick has combined ultrasound and electrical stimulation in a single, attractive console unit, the UT-4300.

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23. Voids in preventive health.
24. Unionization of health personnel.
25. New AMA policies and actions as reported in 1967 clinical session, Houston, Texas, December 1967.
26. Expanded services by MSMS
    a. Foreign programs
    b. Others
27. What MSMS publications are wanted.
28. What improvements can be made in medical care distribution.
29. Purposes and progress of the Health Information Research Institute.
30. Executive secretarial and field services of MSMS to county medical societies and councilor districts.
31. Special conference in February, 1968 on medicine, hospitals, and legal concerns.

At all three conferences, workshops were led by MSMS officers and executive staff members. Invited to participate were key component county medical society officers and delegates.

Following are some excerpts from one of the letters received by MSMS after the conferences:

ATTENTION: Mr. Hugh Brenneman

The enthusiasm for and the breadth of knowledge of the many medical problems facing the profession today, which you and your staff possess, is a never ending source of amazement to me. This has never been better demonstrated, to my knowledge, than in this leadership conference program on which you are currently embarked, and to which I appreciate being invited a couple days ago.

I was most impressed that there was no problem introduced, to my knowledge, that you and your staff were not well qualified and willing and anxious to discuss to any depth that anyone wished to proceed to. I do not know how you people do it. You are a great team. I am very proud of you and very pleased and happy in the knowledge that men such as you and your associates are doing your best to represent us in Lansing and on the national scene.

—Frank H. Power, M.D.,
Traverse City

Strong Voice Needed

"We are living in a social, economic and governmental climate in which medicine needs the strongest possible voice in order to state the profession's side of the literally hundreds of issues that are being raised for consideration by the public and by the legislative bodies of our nation."

—Milford O. Rouse, M.D.
AMA President

Say you saw it in Michigan Medicine

Save this Article; Changes In Medicare, Medicaid Listed

BY HERBERT MEHLER
OF THE MSMS STAFF

When President Johnson signed into law the Social Security Amendments of 1967 on January 2, several major changes in Medicare and Medicaid occurred.

Listed below are the important revisions. Following each change, where appropriate, you will find listed the old provisions for comparison.

MEDICARE

PAYMENT OF MD's BILLS

PERMITS PAYMENT EITHER TO PATIENT ON BASIS OF AN ITEMIZED BILL (EITHER RECEIPTED OR UNPAID) OR TO THE PHYSICIAN UNDER THE ASSIGNMENT METHOD.

Formerly: Payment only by assignment to physician or to patient on presentation of a receipted bill.

DRUG PROPOSALS

HEW REQUIRED TO STUDY AND REPORT TO CONGRESS BEFORE JANUARY I, 1969, SAVINGS WHICH MIGHT ACCRUE AND THE EFFECTS ON THE HEALTH PROFESSIONS AND THE DRUG INDUSTRY RESULTING FROM THE POSSIBILITY OF ENACTING TWO PROPOSALS:

1. COVER PRESCRIPTION DRUGS UNDER MEDICARE
2. ESTABLISH, THROUGH A FORMULARY COMMITTEE, QUALITY AND COST CONTROL STANDARDS FOR DRUGS PROVIDED UNDER THE VARIOUS PROGRAMS OF SOCIAL SECURITY ACT.

RADIOLOGISTS' and PATHOLOGISTS' SERVICES

PERMITS PAYMENT OF FULL REASONABLE CHARGES FURNISHED TO HOSPITAL IN-PATIENTS, EFFECTIVE 4/1/68.

These charges are reimbursed 100 per cent. They are not subject to the deductible and co-insurance.

OUT-PATIENT HOSPITAL SERVICES

TRANSFERS HOSPITAL OUT-PATIENT DIAGNOSTIC SERVICES FROM HOSPITAL INSURANCE PROGRAM TO SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, EFFECTIVE 4/1/68.

CERTIFICATION

ELIMINATES PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY FOR HOSPITAL OUT-PATIENT SERVICES AND ADMISSIONS TO GENERAL HOSPITALS.

Retained is certification of medical need for Psychiatric, TB hospital services, ECF, HHA services, inpatient hospital services furnished over a period of time.

ADDITIONAL DAYS

PROVIDES LIFETIME RESERVE OF 60 DAYS OF HOSPITAL CARE AFTER THE 90 DAYS COVERED IN A "SPELL OF ILLNESS" HAS BEEN EXHAUSTED. CO-INSURANCE AT $20 PER DAY APPLICABLE FOR ADDED DAYS OF COVERAGE.

PODIATRISTS

INCLUDES DEFINITION OF PHYSICIAN A DOCTOR OF PODIATRY BUT ONLY TO FUNCTIONS AUTHORIZED BY THE STATE. NO PAYMENT FOR ROUTINE FOOT CARE WHETHER PERFORMED BY PODIATRISTS OR A MEDICAL DOCTOR.

PHYSICAL THERAPY

EFFECTIVE 7/1/68 EXTENDS PROVISIONS TO INCLUDE OUTPATIENT PHYSICAL THERAPY BY PHYSICAL THERAPISTS EMPLOYED BY OR UNDER AN AGREEMENT WITH AND UNDER SUPERVISION OF HOSPITALS AND OTHER PROVIDERS OF SERVICES AS WELL AS APPROVED CLINICS.

PORTABLE X-RAY

PERMITS PAYMENT FOR DIAGNOSTIC X-RAYS IN PATIENT'S HOME OR NURSING HOME. COVERED UNDER SUPPLEMENTAL MEDICAL INSURANCE PROGRAM IF PROVIDED UNDER SUPERVISION OF PHYSICIAN AND PERFORMED UNDER PROPER HEALTH AND SAFETY REGULATIONS.

MEDICAL EQUIPMENT

PERMITS PAYMENT TO BE MADE FOR DURABLE MEDICAL EQUIPMENT NEEDED BY AN INDIVIDUAL, WHETHER RENTED OR PURCHASED.

HEALTH PRACTITIONERS

HEW TO STUDY NEED FOR, AND MAKE RECOMMENDATIONS ABOUT, EXTENSION OF COVERAGE UNDER SUPPLEMENTAL MEDICAL INSURANCE PROGRAM TO THE SERVICES OF ADDITIONAL TYPES OF PERSONNEL ENGAGED IN THE INDEPENDENT PRACTICE OF FURNISHING HEALTH SERVICES.

ADVISORY COUNCIL

HEW WILL ESTABLISH TO STUDY PROBLEMS RELATIVE TO INCLUDING DISABLED UNDER HEALTH INSURANCE PROGRAM AND ANY SPECIAL PROGRAMS WITH REGARD TO COSTS INVOLVED IN SUCH COVERAGE. COUNCIL TO REPORT BY JANUARY 1, 1969.

MENTAL - TUBERCULOSIS

LIMIT ON PAYMENT OF HOSPITAL INSURANCE BENEFITS DURING FIRST "SPELL OF ILLNESS" FOR AN INDIVIDUAL WHO IS AN INPATIENT OF A PSYCHIATRIC HOSPITAL AT TIME HE BECOMES ENTITLED TO BENEFITS IS INAPPLICABLE TO BENEFITS FOR SERVICES IN GENERAL HOSPITAL IF SERVICES ARE NOT PRIMARILY FOR THE DIAGNOSIS OR TREATMENT OF MENTAL ILLNESS.

THE CHANGE REMOVES TUBERCULOSIS HOSPITALS FROM PROVISION UNDER WHICH DAYS IN A TB INSTITUTION IMMEDIATELY BEFORE ENTITLEMENT TO HOSPITAL INSURANCE ARE COUNTED AGAINST THE DAYS OF COVERAGE. THIS CHANGE MAKES THE INDIVIDUAL'S ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS THE SAME IF HE RECEIVED HOSPITAL SERVICES IN A TB HOSPITAL AS IN A GENERAL HOSPITAL.

COORDINATION

ALLOWS STATES UNTIL JANUARY 1, 1970 TO BUY-IN TITLE 18 SUPPLEMENTARY MEDICAL INSURANCE. PERSONS ELIGIBLE FOR MEDICAID BUT NOT RECEIVING CASH ASSISTANCE MAY BE INCLUDED.

Former deadline was January 1, 1968.

MEDICAID

LIMITATION ON FEDERAL PARTICIPATION

STATES LIMITED IN SETTING INCOME LEVELS FOR FEDERAL MATCHING PURPOSES TO 133⅓% OF THE AFDC PAYMENT LEVEL. (FROM JULY - DECEMBER, 1968 THE PERCENTAGE IS 150%, AND FOR CALENDAR YEAR 1969 IT IS TO BE 140%.) THIS AMENDMENT WILL NOT EFFECT FEDERAL MATCHING FOR MEDICAL CARE FOR PERSONS RECEIVING OR ELIGIBLE FOR CASH ASSISTANCE IF NOT INSTITUTIONALIZED.

DIRECT BILLING - MEDICAID

STATES PERMITTED TO MAKE DIRECT PAYMENT TO THE RECIPIENT FOR PHYSICIANS' SERVICES WITH RESPECT TO THOSE MEDICAL ASSISTANCE RECIPIENTS WHO ARE NOT ALSO RECEIVING CASH ASSISTANCE.

Formerly states were required to pay for health services directly to provider.

REQUIRED SERVICES

THE STATES REQUIRED TO PROVIDE FIVE BASIC SERVICES TO ALL MONEY PAYMENT RECIPIENTS. FOR MEDICALLY INDIGENT, STATES ALLOWED TO SELECT EITHER THE BASIC FIVE, OR SEVEN OUT OF FOURTEEN, SERVICES AUTHORIZED UNDER THE LAW, EXCEPT THAT IF NURSING HOME OR HOSPITAL CARE SERVICES ARE SELECTED, STATE MUST ALSO PROVIDE PHYSICIAN'S SERVICES IN THOSE INSTITUTIONS. AFTER JULY 1, 1970, REQUIRES HOME HEALTH SERVICES FOR CASH ASSISTANCE RECIPIENTS.

SKILL NURSING HOME STANDARDS

STATES REQUIRED TO PLACE ASSISTANCE RECIPIENTS IN LICENSED NURSING HOMES ONLY MEETING CERTAIN CONDITIONS. ALSO PROVIDES FOR A PROFESSIONAL MEDICAL AUDIT PROGRAM FOR PERIODIC MEDICAL EVALUATIONS OF APPROPRIATENESS OF CARE IN NURSING HOMES, MENTAL HOSPITALS AND OTHER INSTITUTIONS.

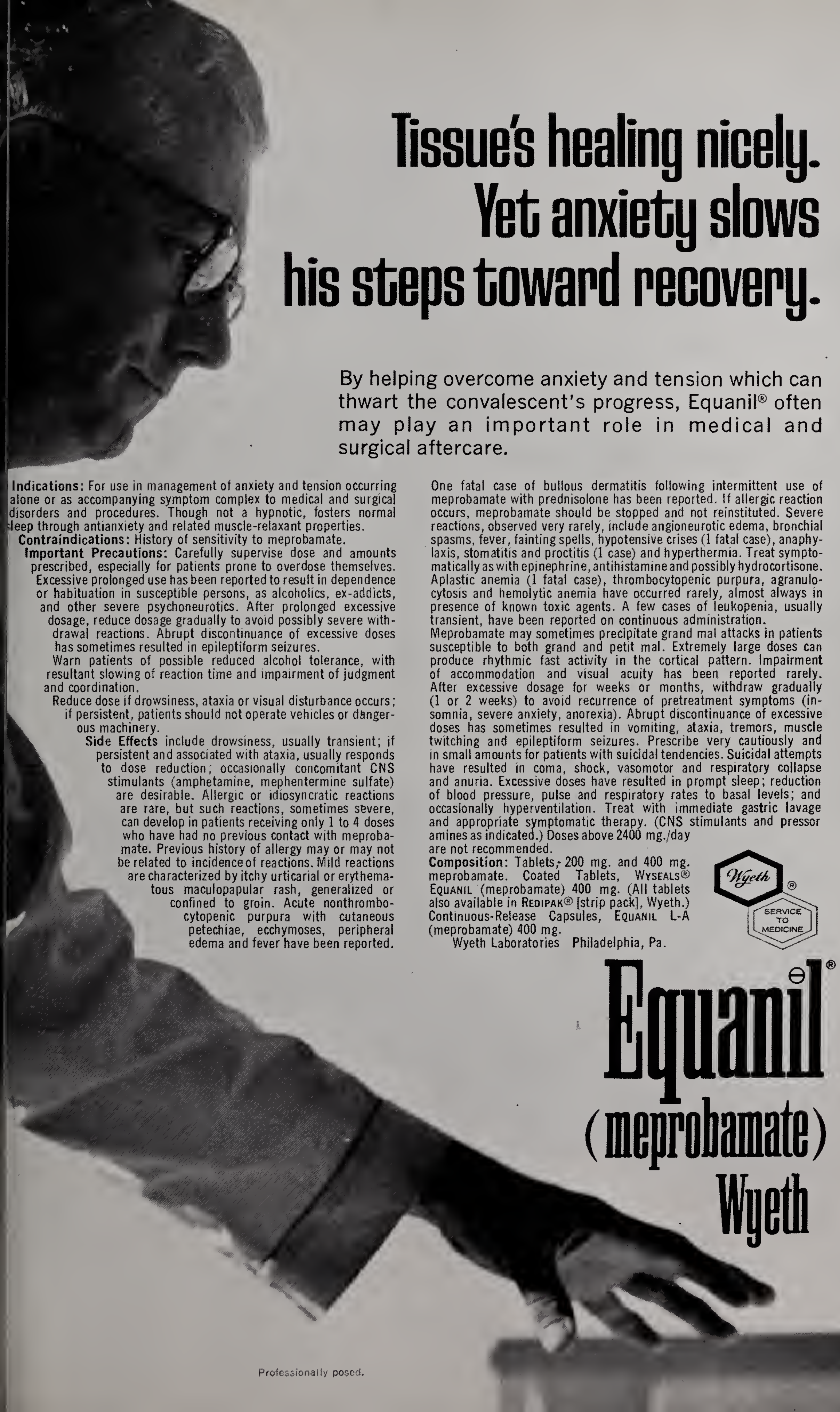
ADVISORY COUNCIL ON MEDICAL ASSISTANCE

ESTABLISHES A COUNCIL OF 21 PERSONS FROM OUTSIDE OF GOVERNMENT TO ADVISE HEW ON ADMINISTRATION.

SAFEGUARDS

REQUIRES STATES TO ESTABLISH METHODS AND PROCEDURES DESIGNED TO SAFEGUARD AGAINST UNNECESSARY UTILIZATION OF HEALTH CARE AND SERVICES, AS WELL AS TO ASSURE THAT PAYMENTS (INCLUDING PAYMENTS FOR DRUGS) DO NOT EXCEED REASONABLE CHARGES AND

Continued on Page 286



Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, Equanil® often may play an important role in medical and surgical aftercare.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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THAT THEY ARE ON BASIS CONSISTENT WITH EFFICIENCY, ECONOMY, AND QUALITY OF CARE.

FAMILY PLANNING

REQUIRES STATES TO OFFER FAMILY PLANNING SERVICES TO ALL APPROPRIATE AFDC RECIPIENTS. PROVIDES FOR FEDERAL MATCHING, INCREASES AUTHORIZATION FOR MATERNAL AND CHILD HEALTH PROGRAMS, DEVELOPMENT OF DEMONSTRATION PROJECTS FOR THE PROVISION OF FAMILY PLANNING SERVICES FOR THE MOTHERS IN NEEDY AREAS. ACCEPTANCE OF FAMILY PLANNING SERVICES TO BE VOLUNTARY AND NOT A REQUISITE FOR RECEIPT OF ASSISTANCE.

FORMULA GRANT PROGRAM

PROVIDES FOR EARLY IDENTIFICATION AND TREATMENT OF CRIPPLED CHILDREN.

The change amends Title 18 to conform to this requirement.

PROJECT GRANTS

AUTHORIZES PROJECT GRANTS UNTIL JULY, 1972 TO HELP REDUCE INCIDENCE OF MENTAL RETARDATION AND OTHER HANDICAPPING CONDITIONS CAUSED BY COMPLICATIONS ASSOCIATED WITH CHILDBEARING, AND TO HELP REDUCE INFANT AND MATERNAL MORTALITY. PROMOTES HEALTH OF CHILDREN AND YOUTH OF SCHOOL AND PRE-SCHOOL AGE AND TRANSFERS RESPONSIBILITY TO THE STATES BEGINNING JULY, 1972.

OPTOMETRIC SERVICES

ALLOWS PERSONS RECEIVING HEALTH SERVICES UNDER CHILD HEALTH PROGRAMS TO UTILIZE SERVICES OF OPTOMETRISTS WHEN APPROPRIATE.

SOCIAL SECURITY AMENDMENTS

DISABILITY - DEFINITION

PROVIDES MORE DETAILED DEFINITION FOR WORKERS. GUIDELINES WOULD BE PROVIDED UNDER WHICH A PERSON COULD BE DETERMINED TO BE DISABLED ONLY IF HE IS UNABLE TO ENGAGE IN ANY KIND OF SUBSTANTIAL GAINFUL WORK EXISTING IN THE GENERAL AREA OF RESIDENCE AND ALSO PROVIDES A SPECIAL MORE RESTRICTIVE DEFINITION APPLYING TO WIDOWS AND WIDOWERS.

BLINDNESS

CHANGES DEFINITION OF DISABILITY SO THAT A PERSON "INDUSTRIALLY BLIND" (i.e. VISUAL ACUITY OF 20/200 OR LESS CORRECTED OR A VISUAL OF 20 DEGREES OR LESS) IS DISABLED.

The change amends visual acuity of 5/200 or less corrected.

INCREASED BENEFITS — and COSTS

The new law provides for increased benefits of 13% for beneficiaries. Higher benefit checks are first payable in February, 1968 and will be reflected in the March checks.

An increase of benefits also means an increase of the tax on earnings. The amount of earnings now subject to tax and used in the compilation of benefits rose from $6,600 to $7,800 on January 1, 1968.

For the self-employed the tax is now 6.4% and will steadily increase to 7.9% in 1987 and after.

AMA Supports S.780 Now in Congress

The American Medical Association supports all except one provision of legislation (S.780) that would expand the federal government's role in the federal-state program to curb air pollution.

In a letter to the Senate Subcommittee on Air and Water Pollution, F. J. L. Blasingame, M.D., executive vice-president of the AMA, pointed out that the AMA has been directing the attention of physicians and other health workers to the problems of air pollution through a series of meetings and its publications. He also noted that the AMA has supported such legislation in past years.

"In spite of past legislation and on-going federal, state and local programs which are carried on in cooperation with private industry, the American Medical Association recognizes that air pollution continues as a major environmental problem," Dr. Blasingame said. "Increased program emphasis on research and development in techniques of air pollution control and abatement is worthy of the support of the medical profession.

"The bill before you contains one provision which we cannot support. Section 107 of S-780 would require the Secretary of HEW to establish emission standards for certain industries. On the basis of present information and understanding of the relationship between emissions and the effect they have on surrounding air, such a requirement is unrealistic and would not accomplish its intended purpose."

NAME JENSEN, GEHRING, FREITAS TO BLUE SHIELD BOARD TO FILL VACANCIES

Three physicians have been elected to the Michigan Blue Shield board of directors to fill vacancies on the board and assure full medical specialty representation.

Elected to one-year terms were William B. Jensen, Jr., M.D., Grand Rapids anesthesiologist and delegate to the American Society of Anesthesiologists; Harold W. Gehring, M.D., chief of orthopedics at William Beaumont Hospital in Royal Oak, and Eugene L. Freitas, M.D., Detroit radiologist and current president of the Detroit Roentgen Ray Society.

The vacancies on the Blue Shield board were created by the death of Harold Dykhuizen, M.D., Muskegon urologist and surgeon, and the resignations of James B. Blodgett, M.D., Detroit cardiovascular surgeon, and Louis F. Hayes, M.D., general practitioner from Gaylord.

Doctor Blodgett resigned in order to take over his duties as Speaker of the MSMS House of Delegates.

Doctor Hayes resigned from the board to become vice president for medical affairs at Blue Shield.

Doctor Jensen is chairman of the Kent County Medical Society disaster committee and the economics and public policy committee of the Michigan Society of Anesthesiologists.

Doctor Gehring, fellow of the American College of Surgeons, holds memberships in the American Fracture Association, Michigan Orthopedic Society and Clinical Orthopedic Society.

Doctor Freitas is a councilor of the American College of Radiology and a member of the Detroit Gastroenterologic Society.

The Blue Shield board includes 21 physicians and 14 lay members.

S.S. Hope to Help Ceylon People in 1968

The various MSMS members who have served on the S.S. Hope will be interested in the 1968 schedule for the mercy ship:

—February 29, 1968 . . . Leave Philadelphia to begin her new mission to Ceylon and her return to Asia

—March 4, 1968 . . . Arrive Ft. Lauderdale, Florida

—March 6, 1968 . . . Leave Ft. Lauderdale for Colombo, Ceylon

—Early April, 1968 . . . Scheduled arrival, Colombo, Ceylon

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in moderate hypertension and
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(when diuretics or sedatives are inadequate, for example)

When your patients expect a lot...

like relief from hypertensive symptoms
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...give them a little
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chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

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Urges Two-Year Medical School For Tri-Cities

Samuel D. Marble, Ph.D., president of Saginaw Valley College, suggested at the Bay, Arenac, Iosco Counties Medical Society meeting January 10 that the possibility of establishing a two-year medical school for the tri-city area be studied.

Doctor Marble reported that the county medical societies of Midland and Saginaw were presently studying the potential for such a school in the area.

At the Bay, Arenac, Iosco Counties Medical Society meeting, it was agreed to study the question. Harry F. Vail, M.D., Society president, said "We're pleased to accept Doctor Marble's proposal. We've appointed a committee to study the question and report its findings to the county society."

AREA SAMA GROUPS TO CONFER AT MSU

A newly organized MSU chapter of the Student American Medical Association (SAMA) will host a regional meeting of SAMA groups from 12 midwestern universities Feb. 2-4 at Kellogg Center.

The conference will focus on changes taking place in medical education and the role of SAMA in organizing students for community health programs.

Discussions will be aimed at crystallizing the region's position on various issues to be taken up at the national convention at Wayne State University in April.

The women's auxiliary of SAMA will hold its regional meeting at Kellogg at the same time.

MSU was selected as host in order to give medical students from other schools an opportunity to see how a new medical program is being developed.

Industrial Nurses Hear Kelley, Birmingham

Frank Kelley, M.D., and Donald Birmingham, M.D., both of Detroit, spoke at the Michigan State Association of Industrial Nurses 20th annual meeting January 26-27 in Detroit.

Doctor Kelley spoke on "Orthopedics as Related to Foot Problems"; Doctor Birmingham discussed dermatology.

The Association of Industrial Nurses now has more than 500 members in Michigan.

DEDICATES SCHOOL

Hugh W. Brenneman, MSMS executive director, was the principal speaker at the recent dedication of the new building of the Mesick consolidated school.

Mr. Brenneman was a teacher at Mesick in 1936, so his dedicatory address was based on personal knowledge of the community and its schools.

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For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 South Michigan
Chicago, Illinois 60604

Say you saw it in Michigan Medicine

IN MEMORIAM

H. D. Dykhuizen, M.D., Muskegon

Harold D. Dykhuizen, M.D., muskegon urologist and member of the Board of Directors of Michigan Blue Shield, died November 25. He was 59.

Graduated with a B.A. degree from Hope College in 1930, he received his M.D. degree from the University of Chicago's Rush Medical School in 1935. His internship and residency were done at the Washington Boulevard Hospital, Chicago. After three years as an instructor in urology at the University of Illinois, he opened practice in Muskegon in 1939. He was a senior urologist and consultant in urology at Hackley Hospital and Mercy Hospital, Muskegon.

Doctor Dykhuizen was president of the Muskegon Medical Society in 1958. He was a Fellow of the American College of Surgeons, the International College of Surgeons, and the American Geriatrics Society. A diplomate of the American Board of Urology, he was a member of the American Urological Association, North Central Urological Section and the Detroit Urological Society.

He was a former director of the Muskegon Children's Home, had been president of the Mona Shores School Board since 1965 and was a member of the Board of Trustees for Hope College. He had served as national chairman of the Alumni Foundation for Hope College and also the University of Chicago. He was on the finance committee of the Muskegon County Republican party.

His medical fraternities were Alpha Omega Alpha and Nu Sigma Nu.

E. L. Whitney, M.D., Detroit

Elmer L. Whitney, M.D., Detroit ophthalmologist, died December 29 at the age of 81.

Doctor Whitney, who was graduated from the University of Kansas Medical School in 1918, had been a member of the staff of the Ford Hospital in Detroit for more than 46 years. For 30 years he served as chief of the hospital's department of ophthalmology and later was senior consultant in that department.

His professional memberships included the Detroit Ophthalmological Society, American College of Surgeons, and American Academy of Ophthalmology and Otolaryngology.

He was a member of Alpha Omega Alpha and Nu Sigma Nu medical fraternities and a Life Member of the Michigan State Medical Society.

D. F. Kudner, M.D., Jackson

Donald F. Kudner, M.D., Jackson surgeon, died December 13 at the age of 71.

Graduated from the University of Michigan Medical School in 1920, he had been practicing in Jackson since 1923. For more than 20 years he served as examining physician for the Jackson County Selective Service Board. He was a member of the Foote Hospital Board of Managers for 15 years.

In the late 1930's Doctor Kudner was involved in a pioneer effort to require immunization of preschool children against whooping cough, smallpox and diphtheria. He was also instrumental in organizing the practical nurse program at Foote Hospital in cooperation with Jackson Community College.

Doctor Kudner was president of the Jackson County Medical Society in 1949 and had also served the society as secretary and treasurer. He once served as chairman of the MSMS Industrial Health Committee. He was a Life Member of MSMS.

He was a Fellow of the American College of Surgeons and a member of the Industrial Medical Association. His medical fraternities were Alpha Omega Alpha and Nu Sigma Nu.

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*LICHT, SIDNEY, ORTHOTICS, Etcetera. New Haven, Conn. 1966. p.390

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MICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 5 MARCH 1968

AMONG THE IMPORTANT ARTICLES:

The "Pap Test" can Save More Lives
Progress Report on Michigan Project ECHO
List of Michigan Communities Wanting Doctors
Legislative Support Needed for MSU Expansion

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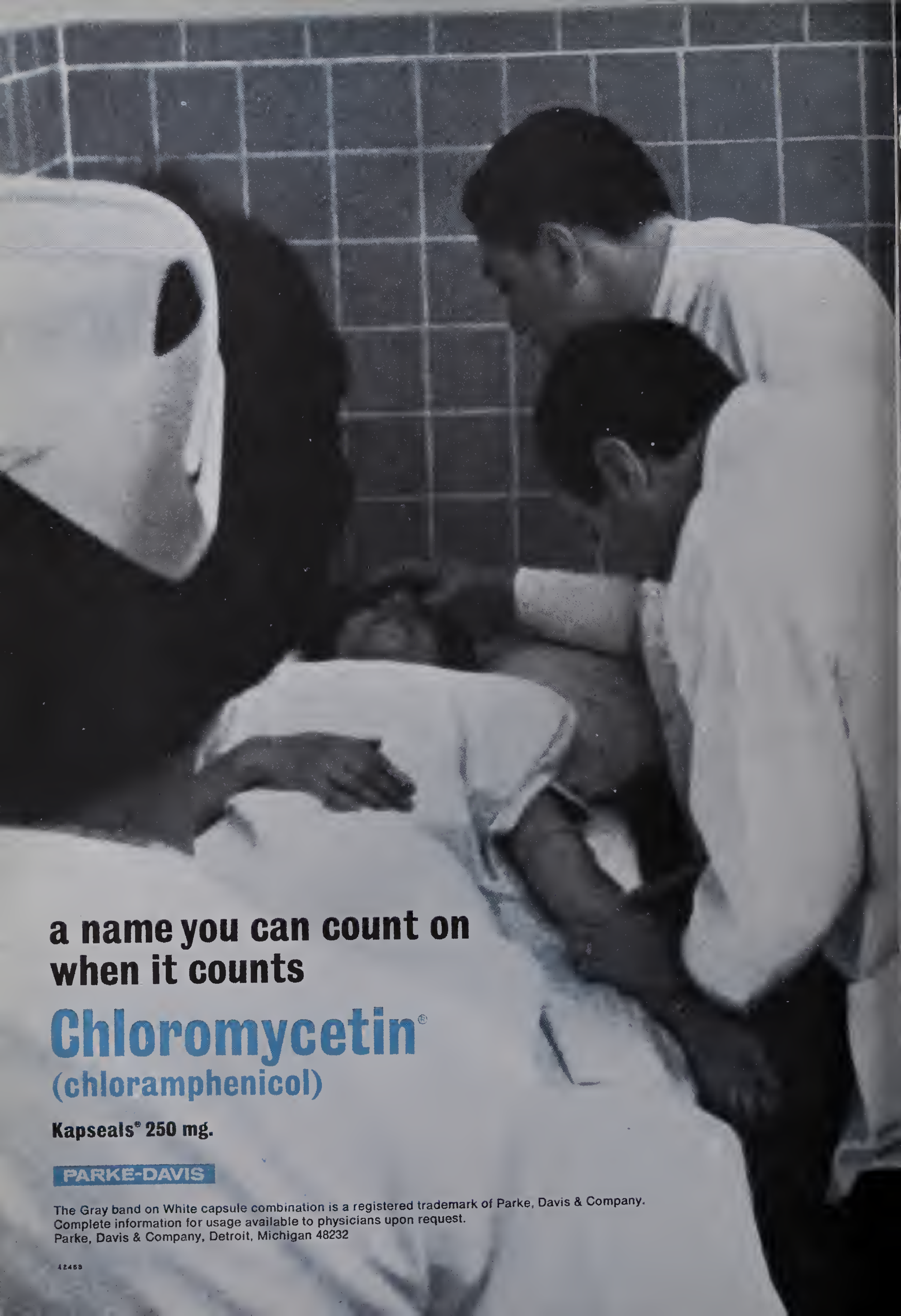

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ABOUT THE COVER:

The cover design was chosen to help promote the Seventh Annual Michigan Conference on Maternal and Perinatal Welfare, in Flint, March 26-27. The mother-child bas-relief was executed by Italy's famed Giacomo Manzu in 1965 as part of the doorway to the Palazzo d'Italia in the Rockefeller Center complex in New York City. The bronze sculptural panel, cast in antique bronze in a Milan foundry, portrays an Italian immigrant mother and child in America. MICHIGAN MEDICINE appreciates the cooperation of the Rockefeller Center in granting permission to print this work by one of the world's foremost living sculptors.

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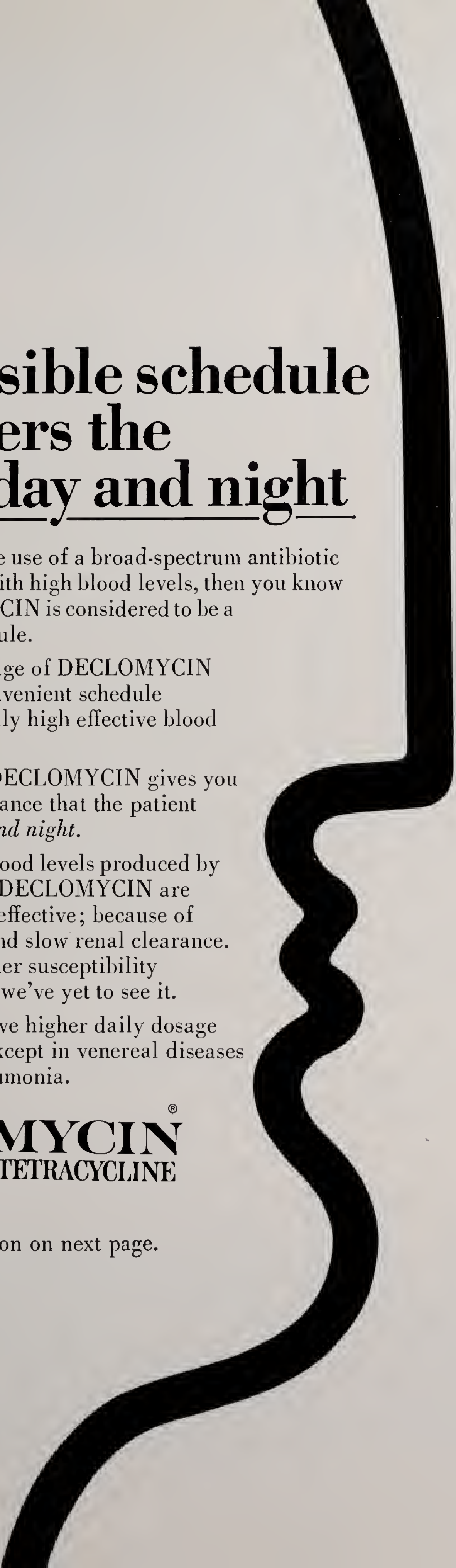

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Playing the Numbers Game

You don't have to go to Las Vegas to get into a pretty fancy numbers game these days.

You can get involved in your own living room — almost every time you pick up the newspaper or listen to radio or television.

The game is played with statistics, with the opportunists twisting them to help him prove some biased view. Social welfare empire builders, politicians, and others know the power of figures and often the target is the doctor of medicine and medical organization.

How do you answer them?

THERE IS NO EASY formula, but the following three suggestions will help you.

First, Recognize the Game. Ask yourself questions like these: "Who is talking?" "Why does he give that ain't-it-awful impression?"

Second, Recognize the Weapons: The opportunist will make his point with glib references like, "according to statistics." When he does that, ask him the source. As physicians and medical organizations, we know how to use vital statistics, numerical charts and tables from authentic studies and organizations.

Third, Have Some Statistics of Your Own: Yes, this will call for study. But the effort will be worth it.

One of the favorite numbers games of the opportunist is to declare that "The AMA doesn't want any more doctors," or "Doctors want to keep down the competition."

THESE GLIB STATEMENTS are so far from the truth. The AMA efforts are tremendous to obtain more doctors. The AMA-ERF has made 35,000 loans totaling $40 million to medical students, interns and residents; AMA members have contributed $50 million to medical schools in the past 10 years; the AMA has actively participated in 11 new medical schools built since 1947; the AMA supported legislation to provide federal grants for medical school construction, etc.

And MSMS has a record equally as impressive. The Health Careers Mobile travels from city to city each week seeking to interest Michigan students in health careers; MSMS has distributed thousands of "Horizons Unlimited" booklets to school counselors, principals, and others; MSMS continues to support efforts to obtain legislative appropriations so the MSU College of Human Medicine can become a four-year school, etc.

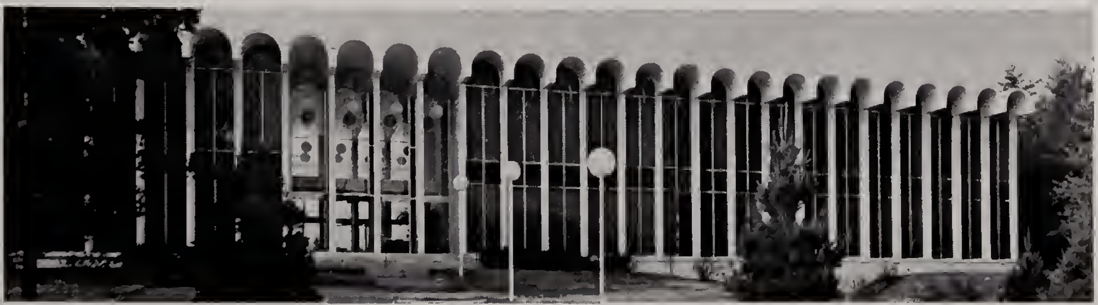
NUMBERS WHICH ATTACK medicine — or education, or the voluntary effort, and other segments of our American society — must be studied carefully.

The stakes in the numbers game are big.

There are opportunities today for every MSMS member to polish up some statistics and help expose the opportunists.

* * *

Hope to see many of you at the excellent Seventh Annual Michigan Conference on Maternal and Perinatal Welfare in Flint, March 26-27.



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VIEWPOINTS

See ECHO Article, Please

BY ROBERT J. MASON, M.D.
CHAIRMAN, THE MSMS COUNCIL

In this issue of *Michigan Medicine,* there appears an article reporting on ECHO, a continuing health survey project of the Michigan State Department of Public Health financed by a grant under the federal Comprehensive Health Planning law.

The scope of ECHO (Evidence for Community Health Organization) will expand during 1968 into more counties and cities. Survey work began in 1967 in seven Michigan cities and counties. Plans call for the entire state to be involved by June 1969.

MSMS MEMBERS SHOULD read the article so they will better understand the purposes of ECHO.

The Michigan Department of Public Health's First ECHO Progress Report, October 1967, declared that, "One of the prime concerns of ECHO is the delivery of timely information to those who plan health programs, to those who deliver health services, and to those who need health services."

ECHO seeks to provide an in-depth study of environmental, social and health problems and point up the needs for remedial programs and action in health services on the local level.

THE ECHO PROJECT obviously is a part of federal comprehensive health care programming. The important roles of the county medical society in this new area of public health were outlined on several occasions by Charles L. Hudson, M.D., while he was the AMA President. In part, Doctor Hudson suggested the following "formula" for the county medical society:

"First, the local medical society must make a public commitment. It must put itself and its members on the line as undertaking the establishment of a comprehensive community health system;

"Second, it must take the initiative in drawing together all the elements of the community that have a legitimate interest in health care, to mobilize their combined efforts in a study of existing health facilities and existing needs within the community;

"And third, again it must take the lead in cooperation with all the combined elements in establishing a program to meet whatever needs are discovered."

MSMS members and committees — and the component medical societies — should study the findings of the surveys.

A COUNTY MEDICAL SOCIETY, it seems to me, should be organized to evaluate its medical coverage for the entire community as it reviews ECHO statistics. The statistics and spot maps should help reveal weak spots and problem areas in health care. Specific medical problems, such as chronic diseases, acute illnesses, immunizations, etc., will be pinpointed.

County medical societies will have new facts and insights now upon which to focus their efforts.

The annual report of ECHO declared that ECHO will provide the opportunities "to pull together and interrelate the separate indices of health, both ill health and good health, so that a community profile at the neighborhood level can be made available on a continuing and ongoing basis and a total community program can be developed, responsive to changing demands and changing needs."

PHYSICIANS, BECAUSE THEY will provide the care to improve health across the state, should become informed and involved early as ECHO expands its original eight areas in 1968 to 34.

As MSMS members seek to learn more about the socio-economic influences on health care, the ECHO article becomes recommended reading.

Legislative Support Needed for MSU Expansion

BY BROOKER L. MASTERS, M.D., CHAIRMAN
PUBLICATION COMMITTEE

The Michigan Legislature this year has the opportunity to practice some very good preventive medicine for the benefit of all the people in the state. By acting favorably on proposals of the state's three medical schools to expand their existing programs, the Legislature will help Michigan avoid serious health care problems in years ahead.

The Michigan State Medical Society's House of Delegates has consistently for several years importuned the Legislature to proceed as rapidly as possible with this expansion, realizing that the need for establishing the clinical years at Michigan State University is clear. MSMS has said that the most logical development of MSU's already existing facilities is clearly the most expeditious way to develop more physicians for Michigan's citizens.

THE WARNING SIGNALS have become obvious. The present supply of physicians is dangerously low and the demand for physicians' services is steadily rising. The Bureau of Health Manpower estimates that the United States needs 50,000 more physicians right now. Included in the estimate are 20,000 physicians to directly serve the public, 10,000 to 15,000 psychiatrists, 10,000 interns and residents and 5,000 physicians for teaching, research, public health and administrative positions.

In addition, many young Michigan residents who want to become physicians are being denied the opportunity to do so because the state's medical schools cannot accommodate all of the state's qualified applicants. The MSU College of Human Medicine alone has received 400 applications from persons who would like to fill one of the 26 spaces in the class that will enter this fall.

OF PARTICULAR IMPORTANCE this year are two specific requests from Michigan State University. One of them is for funds to do detailed planning and initiate construction of the university's proposed Life Sciences Building. This building is needed to permit MSU to expand its present enrollment from entering classes of 26 students to entering classes of 64. The building will also house the School of Nursing and the Department of Pharmacology, enabling MSU to expand enrollments in these vital health areas.

The federal government has indicated that it will grant $5 million toward construction of the $10 million structure as soon as state money is committed. The Kellogg Foundation has already granted $625,000, leaving a balance of $4 million to be appropriated by the state. Of this total, MSU is asking for $1.5 million for 1968-69, $1.5 million for 1969-70 and $1 million for 1970-71.

OF STILL GREATER importance over the long run is a request for $390,000 to enable MSU to plan and begin staffing for a third year, the first step toward expansion to a full, medical degree-granting program. The pressing need for this program was well stated and documented in the report of the Committee on Education for Health Care to the State Board of Education in November of 1966. The State Board subsequently adopted the report and has urged the Legislature and Governor to implement its recommendations.

As physicians of Michigan, we must bring the state's need for expanded medical education to the attention of the people. In this crucial case, the people, through the Governor and legislators, have to provide for health care to protect their own future.

Explains Four MD-PAC Goals

BY VERNON V. BASS, M.D.,
CHAIRMAN, MD-PAC

MD-PAC is preparing for its busiest election year.

Nearly everyone agrees that physicians should take an interest in the races for Congress and the state legislature. We have a responsibility to our patients to help select legislators who recognize health needs and dangers, and will act in the best health interest of the citizens. Legislation and law are necessary to protect the individual from fraudulent diets and medicines, narcotics, substandard hospitals and nursing homes, laboratories, impure foods, etc.

Some of the problems in health care such as those provoked by chiropractors can be solved only at the legislative level. If the physician does not take an interest in medical legislation — who will?

Individual physicians would find it difficult to investigate each of the 138 Representatives and Senators. Outstanding leadership in this vital political area is supplied by twenty-four MD's and two wives of doctors. Each congressional district has an MD-PAC chairman on the State Board of Directors. The MD-PAC board carefully assesses candidates and provides you with this information. Candidate support is based on the voting record of legislators. Candidates are not selected on the basis of political party.

Your MD-PAC Board of Directors has four major objectives during this 1968 election year:

1. A substantial increase in MD-PAC membership.

2. More effective candidate support assistance by physicians and wives.

3. More dollar support to selected legislative friends of medicine.

4. Maximum support to six key Congressional candidates through strong professional organization effort that is adequately financed.

MD-PAC and AM-PAC influence is on the rise and will be even more effective in 1968 with your support. If you have not yet joined . . . send $25.00 to MD-PAC, Box 169, East Lansing, Michigan 48823.

When we elect dedicated Americans we need have no fear of big government, socialism or socialized medicine. We need your help in 1968!

Your Medical Assistant

BY GLENN E. MILLARD, M.D., DETROIT

CHAIRMAN, ADVISORY BOARD, DETROIT MEDICAL ASSISTANTS SOCIETY, THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY, AND THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

The intelligent, pleasant, skilled, and highly-trained medical assistant of today is an integral part of the medical team. In addition to her many professional skills, she promotes good public relations for the physician. Medical assistants are organized in a way similar to that of medical societies. They have state, county, and national organizations.

The American Association of Medical Assistants is 12 years old. Many of the founders are still active members. AMA is now an organization of approximately 15,000 members in 44 states. The Michigan State Medical Assistants Society has approximately 1000 members. Active chapters are present in the more populous counties.

THE MEDICAL ASSISTANT has gained much stature in recent years owing to the greater need for assistance to the physician in both clinical and administrative work. There continues to be a shortage of nursing personnel and a greater need for nurses in hospitals, rather than in doctors' offices. The medical assistant can help fill this void.

In addition, approximately one-third of the physician's time is occupied in administrative details such as writing records in long hand, completing insurance forms, explaining hospital costs, discussing insurance coverage, keeping accounts, and writing absentee forms, etc. Your medical assistant can help you with many of these tasks, leaving you more time to devote to patient care.

The medical assistants in their own behalf are stressing leadership, public relations, education, and certification. To be a leader, the medical assistant must know the requisite qualities for leadership. She must have an ability of self-analysis to correct personality problems that detract from her leadership ability; she must know how to get people to cooperate; she must acquire the methods of public speaking and a knowledge of parliamentary law. To provide training for its officers, the Medical Assistants Society has written guides for officers and committee chairmen; MSMAS has leadership training seminars and other aids to help its members be effective leaders.

The AAMA's five-year-old Certification Board is analogous to the various medical specialty boards. Its advisors are physicians, medical assistants, and national educators on a university level. To encourage medical assistants to become certified, MSMAS sponsors yearly educational and organizational seminars. There are now, at junior college and university levels, seven formal medical assistant programs, one or two years in length. Most are credit courses. Educators are becoming increasingly interested in medical assistant courses on a national level, with the United States government underwriting a substantial portion of the expense of the course.

TO ANSWER THE NEED for a formal medical assistants training program, the AAMA is presently developing an approval program for medical assistant courses. Twelve of the schools now offering medical assistant programs will be inspected by physicians, educators, and medical assistants within the next year as a step in determining a national approval program.

A packet is available from the AAMA which outlines the courses and reference books. It also indicates the suggested amount of time to be allowed for each course. This material will be revised when the national survey has been completed. At present, the course outline includes accounting, collection, record-keeping, anatomy and physiology, examining room techniques, sterilization, care of equipment, laboratory orientation, medical law and economics, medical terminology, office skills (secretarial and administrative), written communications, and human relations.

In the not too distant future national computer systems may be established for most patients in the United States in order to facilitate more nearly complete histories. Automated billing is coming into existence in some areas. Centralized record controls will probably be one of the next steps in automation. Computerized and electronic equipment will continue to be more and more important. All of these aids will increase the need for highly skilled medical assistants.

IN ORDER TO accomplish their objectives, the medical assistants have stressed certain pro-

Continued on Page 313

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grams. They are emphasizing the education and certification programs, and are building an image of the medical assistant consistent with the highest standards of professionalism, identifying her with the medical profession, and working hard to show that they do not presume to overstep their limitations of training to infringe upon the work of other members of the health team. They have a code of ethics very similar to that of physicians. They give active support to legislative issues that are important to physicians. The AAMA has a rapidly-growing scholarship program; it stresses philanthropic projects; it is working in close liaison with the Woman's Auxiliary to the AMA. On a national level the AAMA is affiliated with a number of other organizations.

THE MEDICAL ASSISTANT as the physician's partner in caring for the sick deserves our continued interest and support. Physicians should encourage their assistants to join the MSMAS and the AAMA. Any physician who pays his assistant's dues will receive countless returns on his investment. If you give our medical assistants our loyalty, we can expect loyalty from them. Have you urged and sponsored your medical assistant to join the Michigan State Medical Assistants Society and the American Association of Medical Assistants?

Sees Many Challenges

Each of us must take a personal look at how we feel about our individual and collective involvement in the health care of this country.

Hospitals are participating more and more in this activity, politically birthed agencies and communication media are attempting to involve M.D.'s in an increasing manner, and it is our responsibility to face these challenges and to lead to answers rather than becoming shackled by the answers of non-professional people.

Emergency room care and its attendant responsibilities and liabilities, plus the patient who faces the "no new patients accepted credo" are real challenges deserving real answers.

(The above comments were written by Robert Burrell, M.D., President, Kalamazoo Academy of Medicine, and are excerpted from his monthly message in the Academy's Bulletin.*)*

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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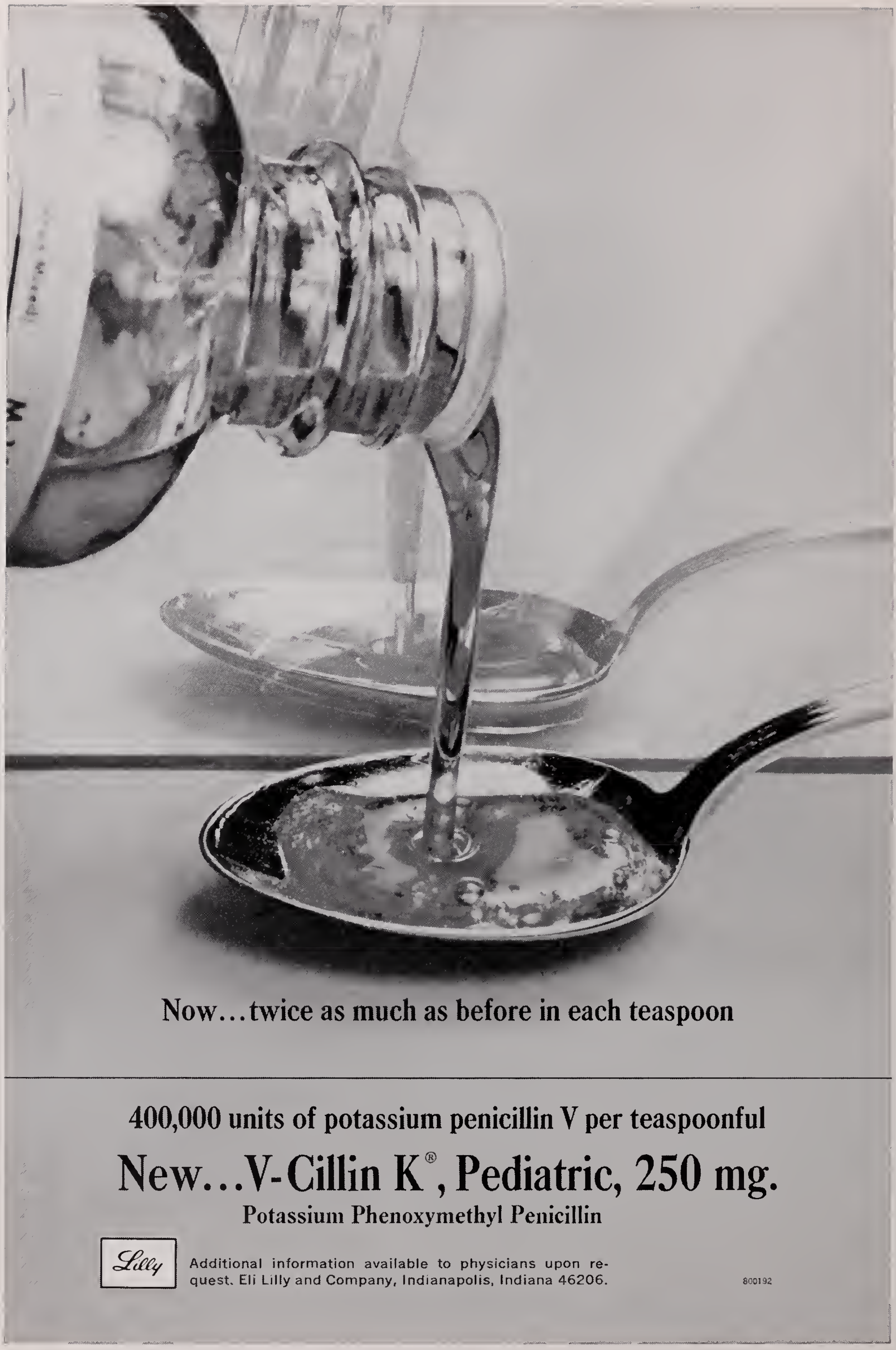

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The "Pap Test" Can Save More Lives; Comments about Research in Detroit, Nation

ABSTRACT: In the United States each year cervical cancer causes 14,000 deaths. All these deaths could be prevented if every adult woman would have a "pap" smear once a year. But only 18% of the adult women in Michigan had this test. Every physician and every adult woman should cooperate to prevent these 14,000 unnecessary yearly deaths.

BY VAINUTIS K. VAITKEVICIUS, M.D.
KAMRAN S. MOGHISSI, M.D.
BOTH OF DETROIT

Preventive medicine is one of the most important, but also one of the least popular parts of the medical school curriculum. Walter Reed had said that "for each patient saved by the glamorous practitioners of clinical medicine, preventive medicine quietly saves thousands."

When entering the medical school, most of us wanted to become physicians healing the sick. As medical students, we were fascinated by patients exhibiting striking physical findings and complaining of unusual symptoms. None of us were very happy when our instructors assigned us patients with no abnormal findings. Throughout most of our medical lives, our own as well as public attention is focused on the ill patient. This concern with the ill unfortunately detracts our attention from the "well" patients.

THIS IS PROBABLY responsible for the observation recently discussed at a meeting of the Michigan State Medical Society Cancer Committee, that only 18% of adult women living in Michigan had ever been subjected to a cytological examination to detect cervix cancer.

When we first heard this figure, our reaction was one of disbelief.

How could this happen when we are so much concerned about the yearly 300,000 cancer death toll which resists all our efforts. The Federal Government alone yearly spends $164,000,000 for cancer research. Cytological screening of nonsymptomatic women for cervical cancer was proven in innumerable studies to be effective in recognizing early curable cancer. Most gynecologists agree that universal use of this simple office procedure could virtually eliminate incurable cervical cancer and thus save some 14,000 women (most of them relatively young) every year from death.

It seemed to us incredible that the "pap" test, which was introduced by George Papanicolaou more than 20 years ago, would not be used much more widely.

A BRIEF SEARCH for facts, however confirms this figure. Of 200 adult women consecutively admitted to a large private hospital in metropolitan Detroit, only 21 ever had a "pap" smear and only 17 remembered having had such an examination within the past year. An inquiry about the utilization of cancer cytology in other cities throughout the country showed about the same results.

Only in Upstate New York these figures are somewhat better. The Albany Medical School and the New York State Health Department offers to practicing physicians of that area intensive educational programs which include such modern innovations as bi-weekly two-way radio conferences. Probably because of such programs, the utilization of cancer cytology in Upstate New York is among the best in the country. However, Doctor Handy, the man responsible for cancer control activities of the New York State Health Department told us that only 28.3% of Upstate New York women in the age groups 25-54 have been reached by the cancer protection program.[1] Doctor Handy's hopes for the future are modest: "If we're lucky, within the next five years we'll be able to reach one-third of this segment of our population."

In spite of this disappointingly low participation of the women in the cytology programs, carcinoma of the cervix is the only cancer showing a real drop in mortality figures attributable to medical efforts. When detected in situ, this cancer is almost always curable. After its onset, it may take a long time to become invasive.

A large study by Peterson in Copenhagen[2] suggests that at least one-third of these cancers will become invasive within ten years. This fortunate tendency of pre-invasive cervical carcinoma to invade slowly gives us a "grace period." In Upstate New York, the ratio of women admitted to the hospital for treatment of invasive cervical carcinoma to that of patients which carcinoma in situ dropped in the last 20 years from 10:1 to 1:1[1].

This ratio would undoubtedly be much better if *all* women past the age of 20 would have yearly "pap" smears.

THE SITUATION in Michigan is quite comparable with that of the rest of the nation. In a recent article, Anderson and Gunn[3] stated that cervical smears reach only 20% of the adult female population in the United States.

What evidence do we have that "pap" smears are responsible for the improving mortality statistics for cervical cancer?

An intensive campaign to educate San Diego county's physician and patient population caused a drop in the uterine cancer death rate from 10 per 100,000 to 5 per 100,000 in a period of six years[4]. The number of patients detected and operated each year for carcinoma in situ by the staff of the Department of Gynecology at Wayne State University rose from 0 in 1953 to 119 in 1966, while the percentage of patients with invasive carcinoma dropped from 100% to 12% (Figure 1).

Among 30,791 new patients examined at Wayne State University affiliated institutions during the period of five years (1962-1967) a total of 487 carcinomas insitu and 117 invasive carcinomas were found[5]. Similar statistics are avilable throughout the country and throughout the world,

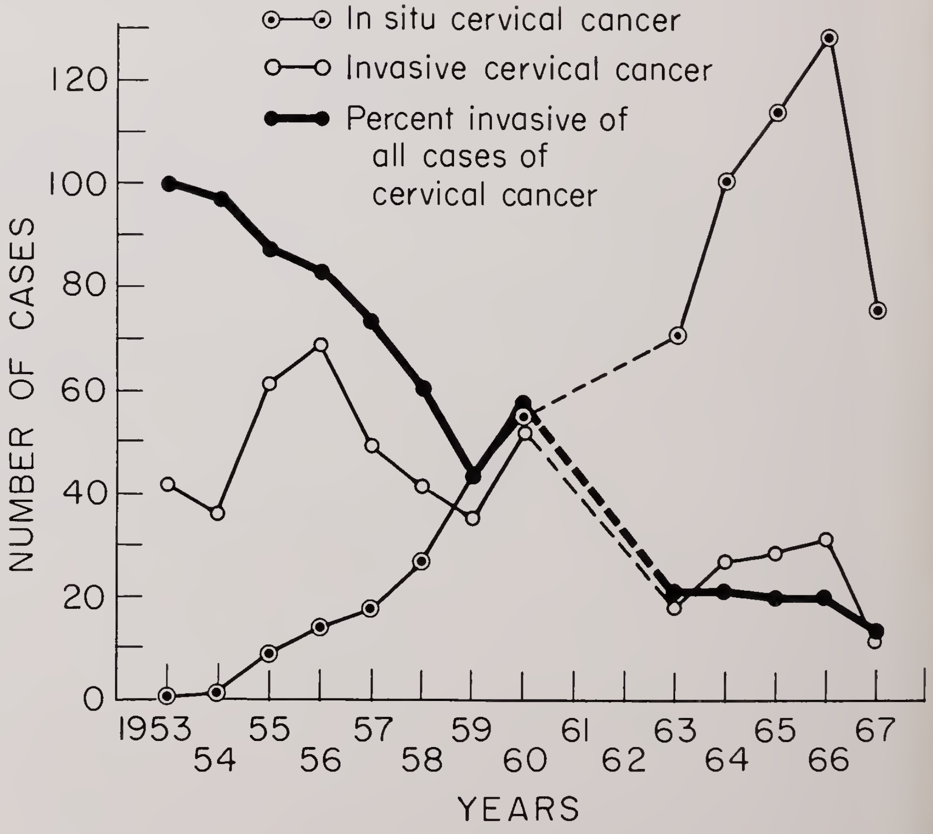

Figure 1: Cervical Cancer detection rate at Wayne State University School of Medicine—Detroit General Hospital program from 1953 to 1967. An extensive cytological screening program was started in January, 1957 and is still continuing. Exact figures for years 1960-1962 are not available. Note the marked decrease in the percentage of invasive cervical cancer from 1953 to present.

wherever the problem of early cancer detection has been studied.

Where and how often should "pap" smears be taken?

There is no question that a complete physical examination carried out by a competent and conscientious physician on an intelligent and cooperative patient followed by indicated laboratory procedures represents the best available means for early detection of any disease. Pelvic examination, in addition to providing an opportunity for direct visualization of the cervix, at which time good quality smears can be obtained, will allow us to detect other pelvic pathologies and therefore should be preferred to any other procedure.

For those patients who do not avail themselves of such an examination, other screening methods such as the collection of vaginal secretions with Davis' cytopipette are available. Cytological smears obtained by this method are about 85% accurate as direct smear[3].

Certainly they are preferable to no examination at all.

However, dependence on such techniques represents an unacceptable assumption that 80% of our female population is either under the care of disinterested or ill-informed physicians, or is too ignorant to seek such help as needed to protect them from fatal cancer. The combined efforts of our medical societies, voluntary health organizations, and mainly the intelligent and trusting cooperation between women and their physicians should be able to eradicate incurable cervical cancer. The importance of such patient-physician cooperation was demonstrated in the same San Diego county's study where 76% of the women receiving "pap" smears admitted that their personal physician was the motivating force for obtaining this examination.

THE INFORMATION is rapidly accumulating that sexual activity starting at an early age is the main etiological factor associated with cervical cancer. Poor personal hygiene of the woman and her partner and sexual promiscuity will increase the frequency of the disease.

A family physician practicing in a suburban community can expect, during a routine examination, to find three to six cervical cancers for every 1,000 patients examined[3].

The physician examining the less fortunate segment of the population will have a much higher rate. The rate of cervical cancer diagnosed as a result of cytological screening during the routine admission physical examination of women admitted to the Detroit House of Correction was 37/1000.[6] A significant number of these women were committed to this institution with the charge of prostitution. The physician responsible for the welfare of imprisoned women can therefore save many more lives from cervical cancer than can a physician in a wealthy suburban neighborhood.

THE RELATIVELY long life history of carcinoma in situ gives us reasonable assurance that if a carcinoma in situ is missed during first examination, it still can be caught in time during the follow-up visit. The exact figure on the frequency of positive "pap" smears among the patients who had previous negative smears is not clear. A number of studies indicate that each year a fairly constant number of new positives will be found in patients who have had a previously negative

VAITKEVICIUS

CO-AUTHORS

Doctors Vaitkevicius and Moghissi are with the Wayne State University School of Medicine; Doctor Vaitkevicius with the Division of Oncology, and Doctor Moghissi with the Department of Gynecology and Obsterics. The article includes reports of "Pap Test" research supported in part by the following grants from the U. S. Public Health Services R2408A66, T12CA8096, and CA07177.

MOGHISSI

smear. This figure is expected to vary with the social and economic background of women examined. However, for each segment of population year after year, it remains remarkably constant. Anderson et al recently followed 2,175 indigent women for three years. During the first follow-up year he found 2.71 postive smears for each 1,000 patients. During the second year the figure was 2.53, and during the third year 2.76 per thousand.

A similar study at Wayne State University's School of Medicine showed a constant yearly incidence figure of 2.4/1000[5]. Statements are being made that after the first two or three negative yearly smears further cytological examinations are not indicated because of the low incidence of positive smears expected.

IT IS TEMPTING to ask whether the individuals making such statements would rather take a two in a thousand chance of dying from a highly symptomatic cancer rather than to subject themselves to a procedure which carries no mortality, no morbidity, and which can be carried out at less expense than a chest x-ray with a time investment of approximately five minutes. It is unlikely to encounter a patient who would want to take this chance.

The government and institutional programs such as Total Action Against Poverty and cancer detection programs sponsored by the universities and Public Health Service are detecting increasingly larger numbers of pre-invasive cervical cancers among the indigent. Invasive carcinoma of the cervix is becoming less and less common in Detroit General Hospital servicing such a population. Admission data in the large private hospitals in Detroit showed a much less impressive improvement.

The members of the Michigan State Medical Society Cancer Committee agreed that these efforts among our indigent population should continue and should be expanded. They also felt, and this feeling was supported by the Council of theMichigan State Medical Society, that a similar campaign should be instituted by every practicing physician.

EVERY PATIENT ENTERING a physician's office, seen by him on a house call, or treated in the hospital, should be encouraged to return for a yearly physical examination even if his health seems to be perfect. No physical examination of an adult woman is complete without a pelvic examination supplemented by a "pap" smear. These cytologic screenings should start at the age of 20 or younger if the patient is sexually active. Possibly the only exceptions from this rule would be young (below 25) women who never had any sexual contacts and patients whose uterus and cervix have been removed.

All informed physicians agree about the value of periodic chest x-ray examinations for non-symptomatic adults and tuberculin skin testings in children entering school, although even the patients with advanced tuberculosis can be helped by available methods of treatment.

The members of the Michigan State Medical Society Cancer Committee feel that routine "pap" smears for early detection of a disease which after becoming advanced may be fatal is certainly indicated. A simple, painless test invented more than 20 years ago is available for every Michigan woman. In the most remote physician's office in the Upper Peninsula, in the examining room of a busy urban practitioner, or in the crowded clinic serving the indigent patient, a simple non-glamorous "pap" smear obtained with a wooden applicator can save more lives with much less cost than ever will be saved by the most expensive high voltage radiotherapy unit. No cancer surgeon will ever save as many lives as a conscientious practitioner practicing this simple form of preventive medicine.

Every physician's office should be a cancer detection center.

No woman should ever develop invasive cervical carcinoma. We can justify cancer research only by using its results.

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Auxiliary Heart Pump Support on Two Cases Of Myocardial Failure following Acute Infarction

BY ARAN S. JOHNSON, M.D.
BERT PRISK
BOTH OF DETROIT

ABSTRACT: The development and testing of devices to provide cardiac and circulatory assistance to failing hearts has become the prime concern of many investigators today.

Reported in this article are two cases of myocardial failure following infarction that were assisted with an auxiliary heart pump.

In recent years, a great deal of attention has been focused on the development of various types of auxiliary and totally replaceable heart pumps to aid failing hearts that do not respond to conventional methods of treatment.

A simple device has been designed and developed by Prisk, et al., that provides this mechanical assistance, when required, following myocardial infarction. This auxiliary pump has been previously described in recent publications as the Substernal Cardiac Massager and Assister. The purpose of this article is to present some interesting clinical data obtained from two treated cases of myocardial failure. The first was an acute infarction while the second was chronic progressive failure several months post-infarction. In the second case, the patient was kept alive and fully conscious with the aid of the pump for thirty-one hours. (See Figures 1, 2, 3, 4)

Case 1

L. K. was a 44-year-old white male truck driver who was admitted through Emergency Room of Harper Hospital on 5-25-67 with a two-day history of severe substernal pain. Past history was essentially negative.

Physical Examination

The patient was a well developed, well nourished, white male in acute distress with respiratory difficulty. He was complaining of vise-like chest pain, radiating into both arms and perspiring profusely. Heart sounds were distant and irregular. Apical rate 100/min. Peripheral pulse rate 100/min. Blood pressure 90/60. Lungs clear. Electrocardiogram was interpreted as an acute anterolateral myocardial infarction.

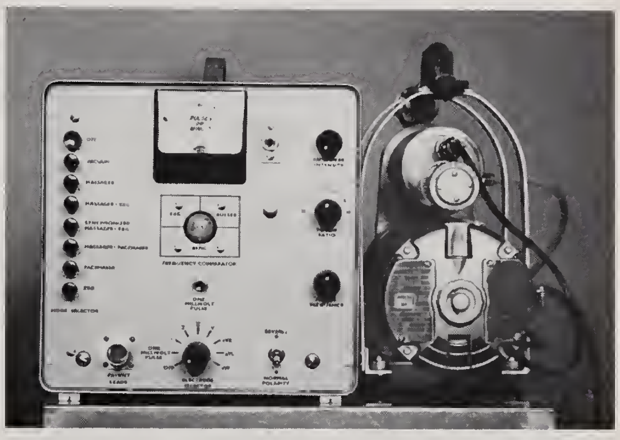

Figure 1: The portable electronic unit on the left, and the cyclic pneumatic pulsator on the right.

Hospital Course

Admitted to the Coronary Care Unit at 12:00 noon on 5-25-67. By 1:45 P.M. the patient developed acute congestive heart failure. Heart rate increased to 140/min, basalar rales heard on auscultation and patient had difficulty breathing. He was digitalized. Heart rate decreased to 88/min, sinus rhythm, with a blood pressure of 100/60. From 4:40 A.M. to 11:00 A.M., the patient developed varying degrees of heart block and finally complete A-V block and syncope. Intravenous Isuprel did not reverse this condition. The patient was sent down to the cardiac catheterization laboratory for insertion of a transvenous internal cardiac pacemaker at 11:00 A.M. ECG at the time showed A-V dissociation, and there was no palpable pulse or blood pressure. The cardiologist was unable to pass the internal cardiac pacemaker beyond the right atrium, although several attempts were made.

Patient developed ventricular fibrillation at 11:40 A.M. External massage, difibrillation and external cardiac pacing were not successful. At 12:17 P.M., the substernal auxiliary balloon pump was inserted into the anterior mediastinum in less

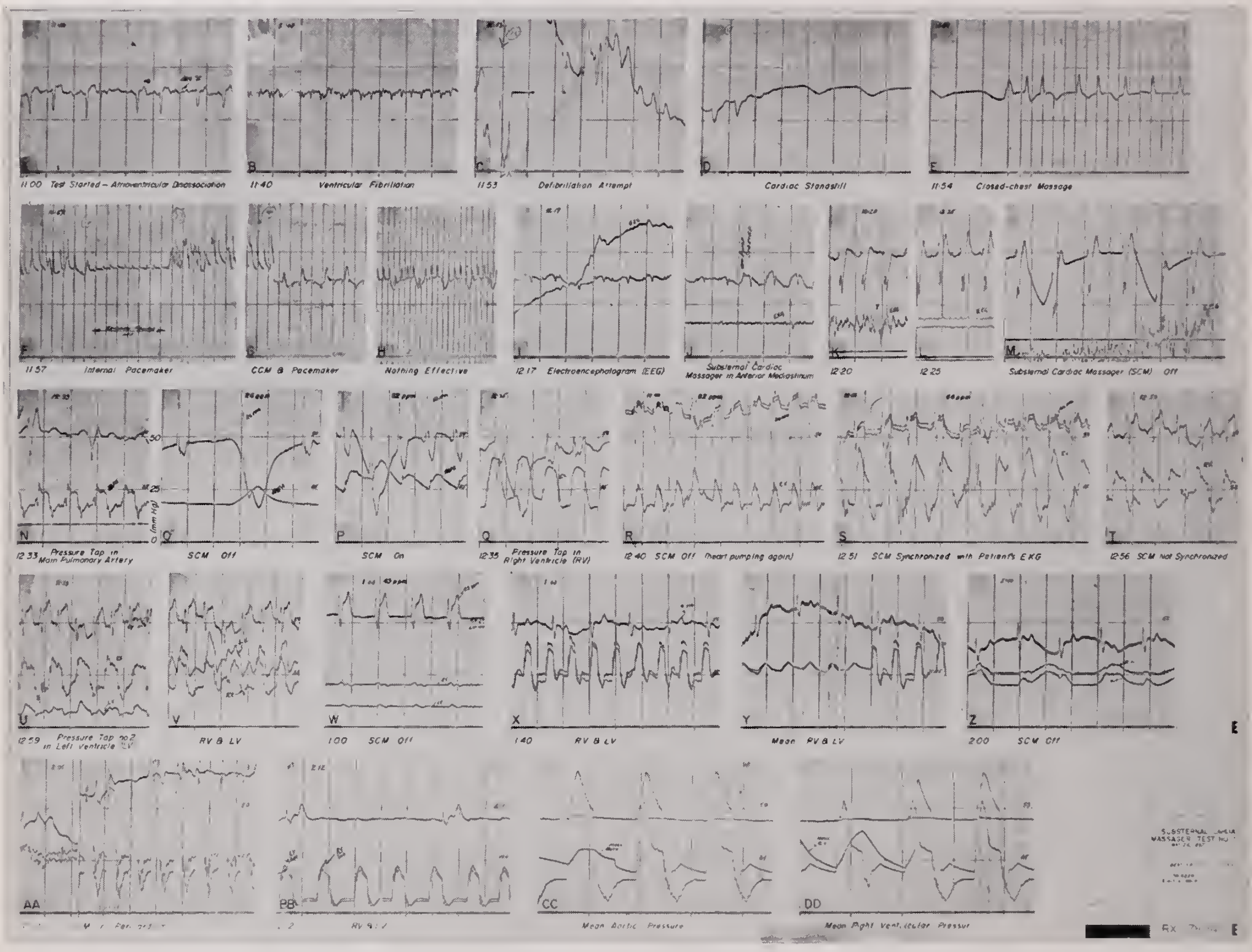
A
11:00 Test Started – Atrioventricular Dissociation
B
11:40 Ventricular Fibrillation
C
11:53 Defibrillation Attempt
D
Cardiac Standstill
E
11:54 Closed-chest Massage
F
11:57 Internal Pacemaker
G
CCM & Pacemaker
H
Nothing Effective
I
12:17 Electroencephalogram (EEG)
J
Substernal Cardiac Massager in Anterior Mediastinum
K
12:20
L
12:25
M
Substernal Cardiac Massager (SCM) Off
N
12:33 Pressure Tap in Main Pulmonary Artery
50
25
0
(mm Hg)
O
SCM Off
P
SCM On
Q
12:35 Pressure Tap in Right Ventricle (RV)
R
12:40 SCM Off (heart pumping again)
S
12:51 SCM Synchronized with Patient's EKG
T
12:56 SCM Not Synchronized
U
12:59 Pressure Tap no 2 in Left Ventricle LV
V
RV & LV
W
1:00 SCM Off
X
1:40 RV & LV
Y
Mean RV & LV
Z
2:00 SCM Off
AA
BB
RV & LV
CC
Mean Aortic Pressure
DD
Mean Right Ventricular Pressure
SUBSTERNAL CARDIAC MASSAGER TEST NO

Figure 2: Serial monitored graphs from Case #1.

than one minute. Figure 1 represents the actual serial monitoring of the EKG. EKG and pressures of this case graphically show the effectiveness of substernal cardiac massage and assistance.

Analysis of Serial Tracings from Case #1

A and B tracings: Deteriorating EKG from A-V dissociation to ventricular fibrillation. Patient's pupils were widely dilated and nonresponsive to light. C through H tracings: Persistent asystole with ineffectual ECM*, EP** and defibrillation. I through M tracings: Gradual improvement in EKG and EEG with SCM***. During this interval, a fibrillating heart which had gone into standstill was converted to sinus rhythm. N tracing: Cardiac catheter was passed into the main pulmonary artery and with SCM the recorded pressures of MPA were 27/mm systolic, 10/mm diastolic. O tracing: SCM off, pressure MPA dropped to zero and the EKG started to deteriorate. P and Q tracings: SCM on, pressure in MPA 19/11 and in Q, pressure up RV 44/7.5. R tracing: SCM off, sinus rhythm, and RV 28.5/16. S tracing: SCM on and synchronized with the patient's EKG. With synchronization RV increased to 45/10. T tracing: SCM on but off synchronization, the pressure in RV decreased to 35/12. U and V tracings: On SCM, RV 34/13 and LV 56/20. W tracing: Off SCM, ventricular pressures dropped to zero, but good sinus rhythm recorded on EKG. X and Y tracings: On SCM, ventricular pressure up to previous SCM pumping levels. The substernal auxiliary balloon was then removed from the anterior mediastinum and inserted into the pericardial sac. The serial tracings AA to DD show more effective cardiac assistance with the balloon in the pericardial sac. The recorded pressures were as follows:

---

* External Cardiac Massager
** External Pacemaker
*** Substernal Cardiac Massager

Systolic mm Hg.	End Diastolic mm Hg.
LV 86	18
RV 67.5	15
LV 88	18
RV 92	16
Aorta 64	20
Aorta 78	28

During the final stages of monitoring, the EKG deteriorated completely, and although the heart was electrically dead the SCM maintained pressure compatible with life. Cineangiocardiogram revealed good movement of radio opaque material (76% Renovest 50 cc per injection) from the right atrium into the lungs with recirculation to the left side of the heart and complete filling of the aorta and its major branches. Left ventricular injection showed good ventricular filling and emptying with the aid of the auxillary heart pump in the anterior mediastinal position as well as in the pericardial sac.

Case 2

G. B. was a 35 year old Negro male with a history of progressive shortness of breath, weakness, rapid heart rate, nausea and vomiting. He was admitted through the Emergency Room of Harper Hospital on 5-28-67.

Past History

This was essentially negative except for an acute myocardial infarction in January, 1967. The patient was digitalized two weeks prior to his admission to Harper Hospital.

Physical Examination

At the time of admission, patient was a well developed, well nourished, 35 year old negro male who was apprehensive, but not in acute distress. Vital signs: BP 110/80 right arm, supine. Pulse 120/min and regular. Respiration 16/min. Lungs: Few coarse rales both bases. Heart: Very distant heart sounds. Apical rate 120/min. Sinus rhythm. Heart enlarged on percussion. Abdomen: Liver down two finger breadths and slightly tender. Extremities: No pedal edema. X-ray of chest: Grossly enlarged heart. Lung fields fairly clear.

Hospital Course

From date of admission to consultation, patient demonstrated progressive cardiac deterioration and irreversible myocardial failure. There was no appreciable response to medical therapeutic measures

ECG: 7-3-67 Acute Anterior Myocardial infraction
7-6-67 Acute anterior wall infarction with digitalis intoxication

On 7-7-67, the patient was semiconscious. Vital signs: BP 70 systolic on palpation. Pulse 130/min. Respiration 26/min. Abdomen: Liver down two finger breadths.

Clinical Impression

Mechanically failing heart result of extensive myocardial damage and fibrosis.

Substernal auxiliary heart pump assistance was recommended. He was transferred to the Coronary

JOHNSON

CO-AUTHORS

Doctor Johnson is a cardiovascular surgeon in Detroit and Mr. Prisk is an engineer, Research Laboratories Division of General Motors Corporation. The initial clinical studies were done at Harper Hospital, Detroit; the research supported by a special grant from General Motors.

PRISK

Care Unit. The urinary output decreased to an average of 7 cc per hour. BP 40-70 systolic on palpation. Pulse 140/min. Respiration 36/min. Lung bases: Increasing coarse rales. On 7-8-67, at 1:50 A.M., under local anesthesia, the substernal auxiliary heart pump was inserted into the anterior mediastinum at the bedside. The auxiliary heart pump was then synchronized to the patient's ECG. Between 2:30 A.M. and 4:00 A.M., patient had become more responsive, BP increased to 100 systolic on palpation and the urinary output had increased to 90 cc within 1½ hours. 4:30 A.M., vital signs more stable. BP 110/60 right arm on auscultation. Heart rate 120/min. Sinus rhythm. Respiration 20/min. 4:00 A.M. to 6:00 A.M., cardiac function continued to improve with an increase in urinary output to 60 cc every half hour. Vital signs remained stable. The patient was fully

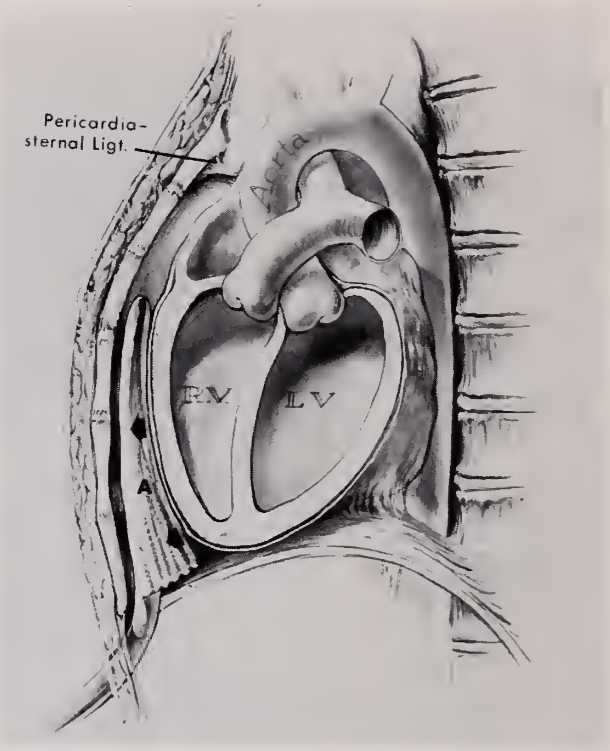

Figure 4: A. Pulsating cardiac ballon assister in diastole (Balloon under vacuum)

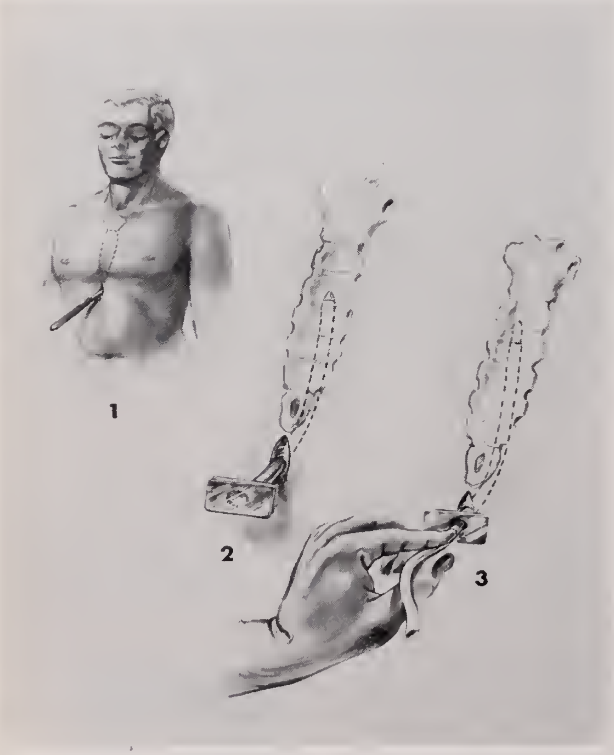

Figure 3: Diagrams showing technique of insertion of the cardiac assister in 3 steps.

1. Small incision tip of xyphoid
2. Substernal trochar manipulated into the anterior mediastinum.
3. Introducing the substernal balloon cardiac assister thru the lumen of the trochar into the anterior mediastinum.

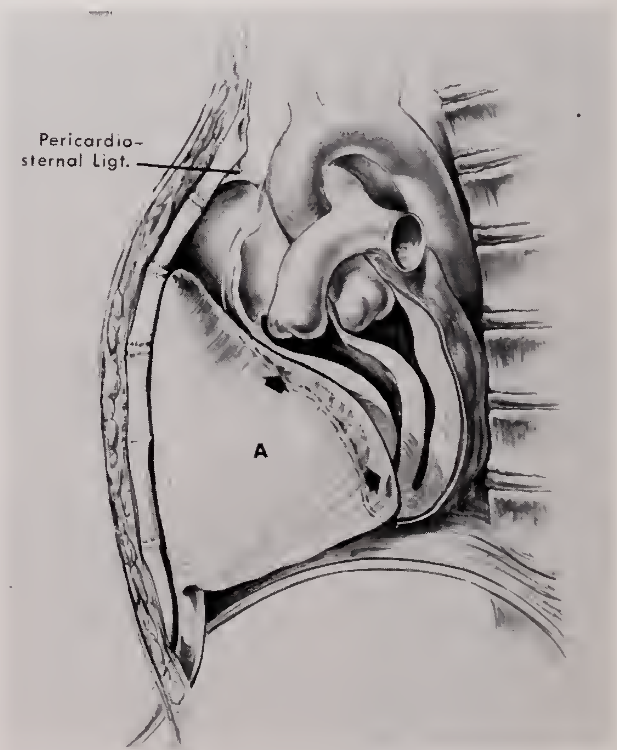

Figure 5: A. Pulsating cardiac balloon assister in systole (Balloon under 15 P.S.I. of pressure.)

responsive and able to talk to his family. On 7-9-67, at 6:30 A.M., cardioscope showed frequent ventricular extra systoles. His urinary output had dropped to 10 cc in the last two hours, heart rate had increased to 138/min and the BP had dropped to 60 systolic on palpation. Patient continued to deteriorate rapidly and died at 9:15 A. M. Total substernal auxiliary pumping time was 31 hours.

Autopsy revealed a grossly enlarged heart. Both right and left ventricles enlarged. Right ventricular wall was very thin, measuring 5 mm in thickness in some areas and the left ventricular 15 mm in thickness. There was diffuse stenosing atherosclerosis involving both right and left coronary arteries with occlusion of the anterior descending branch of the left coronary artery. Histological examination revealed diffuse endocardial and myocardial fibrosis.

Discussion

Scientific data obtained while using the substernal auxiliary heart pump on two patients with acute myocardial infarction. The first patient had developed both mechanical and electrical heart failure following an acute myocardial infraction. From the monitored data, it appears that the auxiliary heart pump in the anterior mediastinum was effective for total cardiac assistance as shown by the ECG tracings in Figure 1. When a uniform electrical QRS complex was obtained and the pump was synchronized with the QRS complex, there was an approximate 30 percent improvement in cardiac assistance by the auxiliary pump. When the pump was placed in the pericardial sac, there was approximately 45 percent improvement in pressure curves over anterior mediastinal auxiliary pumping.

The substernal auxiliary heart pump restored this electrically dead heart to normal sinus rhythm with a cardiac output adequate to maintain tissue life. The pumping was stopped when there was clinical evidence of irreversible CNS damage which had occurred during the attempted insertion of the transvenous cardiac pacemaker.

The second case is a good example of long standing chronic heart failure without CNS damage. The pump was used on this patient after all accepted methods of treatment had failed and patient was developing frequent and more prolonged periods of syncopal attacks due to low cardiac output. While on the auxiliary heart pump, the patient remained mentally alert, maintained stable vital signs and experienced little discomfort. He was assisted for 31 hours before complete loss of myocardial substance and muscle contractility with subsequent irreversible cardiac dilatation and death.

Summary

Use of an auxiliary heart pump on two patients with myocardial failure following acute myocardial infarction has been presented and discussed.

Acknowledgement

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Regional Enteritis Presenting As Acute Arthritis

ABSTRACT: The case of a 15-year-old girl who presented with acute peripheral arthritis seven months before developing classical regional enteritis is described. Synovial fluid and synovial membrane biopsy data, with serological studies, over a two year period of follow-up, are presented. Such serial observations on this disease are considered unique. Differential diagnosis and the clinical manifestations are discussed.

BY WILLIAM R. AUSTAD, M.D.
GEORGE R. THOMPSON, M.D.
RAMON R. JOSEPH, M.D.
ALL FROM ELOISE

While the occurrence of polyarthritis with ulcerative colitis is well recognized, the association with regional enteritis is less common. It is thought to be analogous to the arthritis occurring with ulcerative colitis or Whipple's disease[1]. However, there are considerably fewer descriptions of the arthritis of regional enteritis in the literature, and only three cases have previously been described in which the arthritis preceded the occurrence of bowel disease[2,3,4].

There is only one report of the synovial fluid characteristics and histologic changes in the synovial membrane occurring with regional enteritis[5] and in these cases the tissue was obtained nine and thirteen years after the onset of arthritis.

We have cared for a young Negro girl who initially presented with migratory polyarthritis, subsequently developed erythema nodosum, and finally exhibited the characteristic gastrointestinal manifestations of regional enteritis. Early in her course synovial fluid and synovial biopsy studies were obtained, and these were repeated two years after the onset of her disease, as were serologic tests for the rheumatoid and antinuclear factors. We feel it important to draw attention to these findings as, to our knowledge, this is the first time such serial observations have been available. We also wish to emphasize the need to consider regional enteritis as an unusual association with acute polyarthritis.

Case Report

R.H. (WCGH No. 327506), a Negro female, was first hospitalized in February 1965 at the age of 15 years on the pediatric surgical service with a three-day history of lower abdominal pain and nausea. As the pain subsequently was localized to the right lower quadrant of the abdomen and was accompanied by guarding and rebound tenderness, a diagnosis of acute appendicitis was made. Laboratory studies showed a white blood cell count of 8,600 cells per cubic millimeter, hematocrit of 33%, and 2-3+ proteinuria. A quantitative Kline cardiolipin test was reactive at 1:1 dilution, but the Reiter protein complement fixation test was negative. A laparotomy was performed, with removal of an inflamed appendix, interpreted histologically as chronic periappendiceal inflammation.

The patient was then asymptomatic until April 1965, when she developed intermittent attacks of arthralgia and arthritis. She was hospitalized for the second time in June 1965 with acute pain, swelling, erythema, and tenderness of the ankles and knees. During the interval of time she had lost 20 pounds. She had no abnormal bowel symptoms, and other than the evident arthritis, physical examination was unremarkable. Laboratory studies showed a white blood cell count of 8,300 cells per cubic millimeter, with a normal differential. The hematocrit was 32%, with evidence of iron deficiency (serum iron 18 mcg./100 ml., iron binding capacity 345 mcg./100 ml. with a saturation of 5.2%). The urine was normal except for a trace of protein. Serum uric acid was 4.2 mg./100 ml. The total serum protein was 7.4 gm./100 ml., with electrophoretic separation showing 3.2 gm./100 ml., albumin; 0.36 gm./100 ml. alpha I; 0.81 gm./100 ml. alpha II; 1.07 gm./100 ml. beta; and 1.96 gm./100 ml. gamma globulin. Serological studies revealed a weakly reactive Hyland slide test for the rheumatoid factor; an antistreptolysin-0 titer of 125 Todd units; a non-reactive Kline cardiolipin test; and a negative test for the C-reactive protein. The Wintrobe sedimentation rate was 55 mm./hr., and two L.E. cell preparations were negative. X-rays of the knees and ankles were normal, as was an electrocardiogram. Synovial fluid aspirated from the right knee showed 525 red and 12,300 white blood cells per cubic millimeter (90% polymorphonuclear and 10% mononuclear leukocytes). A good mucin clot was formed on addition of acetic acid. Cultures of the synovial fluid were negative. A diagnosis of possible rheumatoid arthritis was made and the patient was discharged on aspirin and ferrous sulfate.

The third hospital admission occurred in July 1965, because of persistent ankle pain and swelling. Two weeks prior to admission she had noted the onset of red, tender nodules on the skin of her lower legs. She also had developed abdominal pain, worse at night, and relieved by food, antacids, and reduction of her aspirin dosage. Physical examination revealed a further weight loss of 10 pounds. The ankles were swollen, warm, and tender, as subsequently were the knees. Several tender erythematous nodular lesions, typical of the appearance of erythema nodosum, were present on her lower legs.

STUDIES CARRIED OUT during this hospitalization included a white blood cell count of 9,850, and hematocrit of 30%. Serum iron was again low (13 mcg./100 ml.), and blood loss was suspected. However, several stool examinations were negative for occult blood, and upper gastrointestinal X-ray series were normal. Hemoglobin electrophoresis showed AA hemoglobin. Serum calcium, phosphorus and uric acid were normal. Serum protein electrophoresis was similar to that of June 1965. Wintrobe sedimentation rate was 52 mm/hr. Serologic tests showed a 4+ C-reactive protein; non-reactive Kline cardiolipin test, and a weakly reactive Hyland slide test for the rheumatoid factor. L.E. cell preparations were negative, but a fluorescent antibody test for antinuclear factors was positive[6]. X-rays of the chest, knees, and ankles were normal.

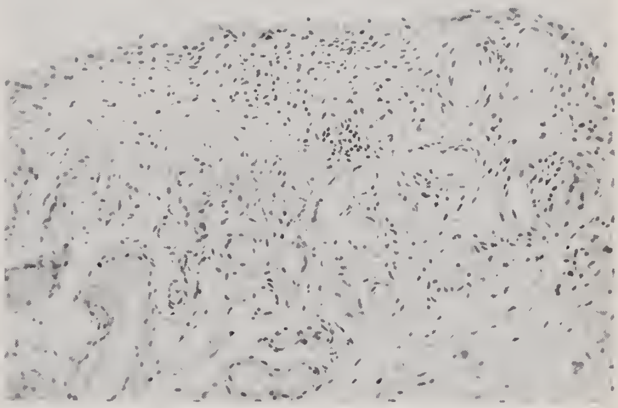

Figure 1: Biopsy of synovium of right knee, July 1965. Note the marked vascularity, some leukocytic infiltration, and fibrinous exudate overlying the synovium (210 X, H.&E.).

CO-AUTHORS

AUSTAD

THOMPSON

JOSEPH

The authors are associated with the Rackham Arthritis Research Unit and Department of Internal Medicine, the University of Michigan, and the Rheumatology and Gastroenterology Sections, Department of Internal Medicine, Wayne General Hospital, Eloise.

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Biopsy of one of the nodules on her lower right leg showed leukocytic infiltration and perivasculitis, changes consistent with erythema nodosum. Tuberculin skin test was negative. Because of the possibility of sarcoidosis, a percutaneous liver biopsy was performed. The specimen showed only a slight increase of chronic inflammatory cells in the portal area, interpreted as being a nonspecific change. The right knee joint was aspirated and a needle biopsy was performed, using a Cope needle. The synovial fluid contained 7,000 red and 5,300 white blood cells per cubic millimeter, of which 60% were polymorphonuclear leukocytes and 40% mononuclear cells. There was a good mucin clot on addition of acetic acid, and cultures were again negative. Synovial tissue showed increased vascularity (Fig. 1), an overlying fibrinous exudate, and in other areas synovial cell hyperplasia and inflammatory cellular infiltration. This was interpreted as a chronic, non-specific synovitis. It was thought she had a connective tissue disease, probably systemic lupus erythematosus, and an iron deficiency anemia secondary to blood loss related to salicylate therapy, and poor dietary habits. She was discharged on salicylates, antacids, and ferrous sulfate.

SHE WAS SHORTLY readmitted (for the fourth time) in September, 1965, because of nausea, vomiting and abdominal pain. The pain was described as being knife-like and colicky in character, primarily in the periumbilical area with radiation into the right lower quadrant. The pain was unrelated to and unrelieved by food or antacids; would spontaneously subside after 15-20 minutes, only to recur. Physical examination revealed abdominal tenderness and moderate rebound tenderness with an ill-defined mass palpable in the right lower quadrant. There was an anal fistula present discharging purulent material. The ankles and knees were warm, swollen and tender, and there were erythema nodosum lesions on her lower legs.

Laboratory studies showed 9,950 white blood cells per cubic millimeter (69% polymorphonuclears), hematocrit of 30%, and a negative Kline cardiolipin test. A repeat fluorescent antibody test for antinuclear factors was now negative. Stool examination was positive for blood. Proctosigmoidoscopy revealed a perianal abscess with a fistula-in-ano, but no colonic abnormalities. Barium enema X-ray was normal, but there was non-filling of the terminal ileum. An upper gastrointestinal examination with small bowel studies showed a normal stomach and duodenum, but narrowing of the lumen, fistula formation, and "a string sign" in the terminal ileum (Fig. 2). These findings were interpreted as being diagnostic of regional enteritis.

The patient was treated with antispasmodic drugs and antibiotics. Because of unresponsiveness to medical therapy a laparotomy was performed revealing thickened, edematous terminal ileum with firmly adherent loops of adjacent ileum. The cecum and colon were normal. The diseased bowel was resected and an end-to-end ileocolostomy performed. The resected specimen contained several intestinal fistulous tracts and microscopically showed a severe acute and chronic ulcerative inflammatory process involving the mucosa, submucosa and focally extending through all muscle layers into the serosa. The process was also marked by extensive edema and vascular granulation tissue. These findings were considered consistent with the diagnosis of regional enteritis.

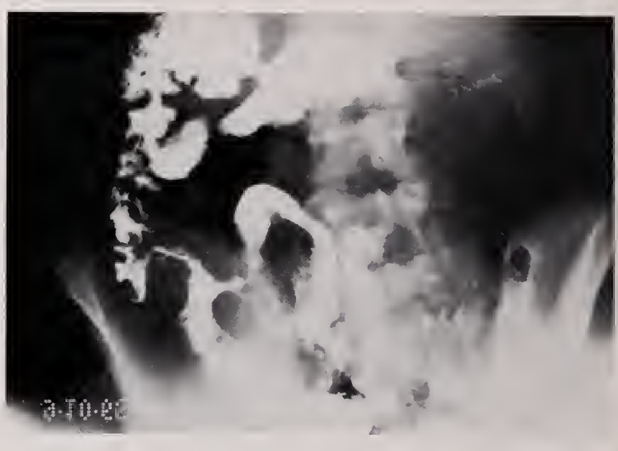

Figure 2: Small bowel X-ray, September 1965. Note narrowed lumen with "string sign," and fistula formation in terminal ileum, typical of regional enteritis.

POSTOPERATIVELY THE PATIENT did very well and by the fifth postoperative day the arthritis and skin lesions (erythema nodosum) had markedly diminished. The anal fistula healed spontaneously, and she was discharged much improved.

During the subsequent 18 months she has continued to do well. The skin lesions of erythema nodosum have not recurred. With dietary indiscretions she has noted the occurrence of diarrhea, with up to seven stools per day, lasting only two-three days, and clearing spontaneously with resumption of a normal diet. She has also had occasional attacks of arthritis in the knees and ankles, lasting one-two days, always responding to salicylate therapy. She has attended high school, and has lived a normal life.

In April 1967 she was admitted for the fifth time because of acute arthritis in both ankles and the left knee. Two weeks prior to admission she had developed gastroenteritis, with fever, nausea, vomiting, and diarrhea (seven loose stools per day). Subsequently arthritis developed. The fever, nausea, vomiting, and diarrhea cleared shortly. However, the arthritis persisted, necessitating hospitalization. Examination showed the ankles to be

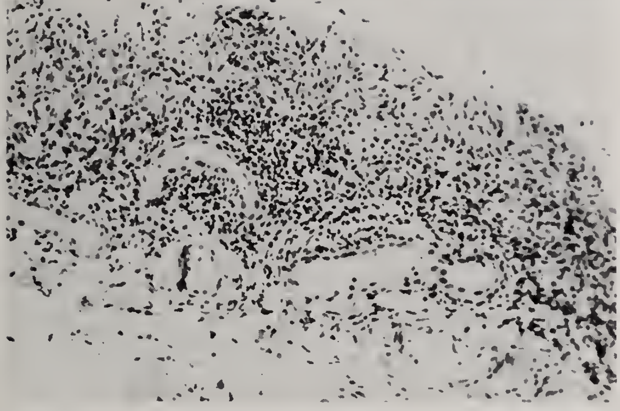

Figure 3: Biopsy of synovium, left knee, April 1967. Note marked inflammatory infiltration, with synovial hyperplasia. This is interpreted as a chronic active synovitis (280 X, H.&E.).

warm, swollen, red and very tender. The left knee was swollen and tender. The abdomen was soft and non-tender. Laboratory studies revealed a white blood cell count of 7,750 cells per cubic millimeter hematocrit 34.5%. The Wintrobe sedimentation rate was 52 and 57 mm./hr. on two occasions, and the test for the C-reactive protein was 4+ positive. L.E. cell preparations were negative, as was a fluorescent antibody test for antinuclear factors. A Hyland slide test for the rheumatoid factor was weakly reactive. Total serum proteins were 7.1 gm./100 ml., with 2.6 gm./100 ml. albumin; 0.31 gm./100 ml. alpha I; 0.77 gm./100 ml. alpha II; 1.08 gm./100 ml. beta; and 2.34 gm./100 ml. gamma globulin. X-rays of the chest, knees and ankles were normal, and an upper gastrointestinal X-ray series with small bowel detail studies revealed no evidence of recurrent ileitis. The left knee joint was aspirated, and a synovial biopsy performed with the Cope needle. Synovial fluid contained 400 red blood cells, and 10,000 white blood cells (93% polymorphonuclear and 7% mononuclear leukocytes) per cubic millimeter. Addition of acetic acid gave a good mucin clot. Synovial tissue (Fig. 3) showed an active, chronic, productive synovitis. The patient was treated with rest, salicylates, and a short course of phenylbutazone, with complete clearing of her arthritis. She was discharged asymptomatic ten days after admission.

Discussion

It is quite possible that the first symptoms of regional enteritis in this girl were those resembling appendicitis in February 1965. Supporting this would be the biologic false positive test for syphilis (positive Kline, negative Reiter's protein complement fixation test), which subsequently became negative. Somewhat against this are the absence of findings suggestive of regional enteritis at appendectomy and her rapid and complete recovery after surgery. However, regional enteritis involving the cecum and the base of the appendix has been indicted as causing appendicitis with no other findings at laparotomy.[7]

The diagnosis of regional enteritis was established in this patient by characteristic radiologic changes in the small bowel. (Fig. 2) The negative proctosigmoidoscopy and the negative colon examination made ulcerative colitis unlikely. The radiologic findings were confirmed at laparotomy, and the histologic changes in the resected small bowel were those of regional enteritis. The possibility of the patient also having systemic lupus erythematosus exists. However the abscence of renal disease and evidence of serositis during a period over two years is against this diagnosis.

Table 1 summarizes the laboratory data over 26 months of observation. Of particular interest is the transiently positive test for the antinuclear factor. This test was repeated testing the serum of July and September 1965 together in the same run, with again a positive test with the July and negative test with the September serum, making a laboratory error an unlikely explanation. Also of interest is the development of the C-reactive protein in her serum between June and July 1965, and its presence in April 1967, despite relatively mild symptoms in the interim. This is thought to be indicative of continuing activity of the disease process. Supporting this is the fall in serum albumin and rise in gamma globulin between 1965 and 1967. However, there was no radiologic evidence of bowel disease in 1967.

IN PREVIOUS STUDIES of peripheral arthritis associated with regional enteritis, specific serologic tests have been infrequently reported.[2,3,4,5,7,8,9] Biologic false positive test for syphilis

Table 1. Summary of serological and synovial fluid studies during the 26 months patient was followed.

Date	2/65	6/65	7/65	9/65	4/67
Rheumatoid Factor	—	Weakly Reactive	Weakly Reactive	—	Weakly Reactive
S.T.S.*	+1:1	Neg.	Neg.	Neg.	Neg.
L.E. Cell Test	—	Neg.	Neg.	—	Neg.
Antinuclear Factor	—	—	+	Neg.	Neg.
C-Reactive Protein	—	Neg.	4+	—	4+
Serum Albumin	—	3.2 g.	3.24 g.	—	2.6 g.
Serum Gamma Globulin	—	1.96 g.	1.95 g.	—	2.34 g.
Synovial Fluid					
W.B.C.	—	12,300	5,300	—	10,000
% PMNs	—	90	60	—	93
Mucin Clot	—	Good	Good	—	Good

*Serologic Test for Syphilis

has not been previously observed, and tests for antinuclear factors have been negative.[4,10] Tests for the rheumatoid factor have also been negative except when classical rheumatoid arthritis has preceded the occurrence of regional enteritis.[3,4]

Synovial fluid changes were essentially similar in 1965 and 1967. However, the synovial membrane histologically showed an increase in inflammatory cellular infiltration and synovial proliferation in 1967 compared to 1965 (Figs. 1 & 3). While the sampling error is admittedly great with blind needle biopsy, these changes were thought suggestive of progression of the synovial lesion. These histologic changes are similar to those previously described[5], and may be characterized as a chronic, active, synovitis. The synovial fluid findings of a predominantly polymorphonuclear pleocytosis with a good mucin clot test are similar to those reported with ulcerative colitis.[11] Soren, however, found a lesser pleocytosis, predominantly lymphocytic, in his cases of arthritis with regional enteritis.[5]

The occurrence of arthritis with regional enteritis has been reported to vary from 2.5% to 6.5%,[4,7,8,9,10] giving a mean incidence of 3.8%. The incidence of arthritis with ulcerative colitis has been accepted as 4 to 8% though the trend is toward higher estimates with reports of 15 to 20% cited.[3] Erythema nodosum has been reported to occur in 0.83 to 2.1% (mean 1.09%) of patients with regional enteritis,[4,7,8,9] 2.88% of patients with ulcerative colitis[3] and 9.5% of patients with systemic lupus erythematosus.[12] It is listed as an exclusion in the American Rheumatism Association's criteria for the diagnosis of rheumatoid arthritis.[13]

IT IS OUR OPINION that our patient presented several manifestations that may be related to a hypersensitivity type of reaction, i.e., erythema nodosum, transiently positive tests for syphilis, antinuclear factors, and the rheumatoid factor. It is interesting to speculate on the relationship of hypersensitivity to her arthritis and enteritis. In any event, it is well to emphasize that regional enteritis may be an unusual cause of migratory polyarthritis. Earlier small bowel detail X-ray studies might have led to the correct diagnosis of regional enteritis sooner in our patient.

Summary

The case of a 15-year-old Negro girl who presented with acute peripheral arthritis seven months before the development of classical regional enteritis is described. The diagnosis of regional enteritis was established by typical roentgenologic changes in the small bowel, with fistula formation, and a normal colon. These findings were confirmed at laparotomy. The arthritis was associated with erythema nodosum, an elevated sedimentation rate, a transient biological false positive test for syphilis, and the presence of rheumatoid and antinuclear factors in the blood. Synovial fluid examination revealed leukocytosis, predominately polymorphonuclear; and a good mucin clot with the addition of acetic acid. Histologic changes in the synovial membrane were compatible with a chronic, active nonspecific synovitis. Follow-up studies two years later are presented.

This is the first time to our knowledge that such serial observations of the arthritis occurring with regional enteritis have been available. This case further illustrates the diagnostic dilemma presented by a patient with atypical, acute, peripheral arthritis.

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Chlorpromazine and Thioridazine In Severe Mental Deficiency

ABSTRACT: A comparative study of chlorpromazine (Thorazine) and thioridazine (Mellaril) in the treatment of behavior disorders in mental retardates is reported. Global evaluation and change in target symptoms showed thioridazine to be more effective. The increased benefit derived from thioridazine was attributed in part to a greater toleration, notably a reduced incidence of drowsiness, ataxia and Parkinsonism.

BY EROL UCER, M.D.
LAPEER

The effectiveness of the phenothiazines in the treatment of mental disorders, notably schizophrenia[1,2,3] is well-established. Less well-recognized is their apparent usefulness in the treatment of behavior disorders, especially those associated with mental retardation.[4,5,6]

The drugs most widely used for this purpose at this hospital* have been chlorpromazine (Thorazine and thioridazine (Mellaril), each of which has had its adherents among the members of our staff. The comparative study reported here was undertaken in an effort to determine any differences between these two phenothiazines in the management of behavior disorders associated with mental retardation.

Methods and Materials

Eighty extremely retarded female patients who were in satisfactory physical condition were divided into two groups of 40 patients each, one to receive thioridazine, the other chlorpromazine. Patients ranged in age from 15 to 47 years, median age for the patients receiving thioridazine was 28 years, while the median age for those receiving chlorpromazine was 26 years. All of the patients were either congenitally retarded or had experienced birth trauma or postnatal complications and had a low degree of intellectual function. Sixty-four patients had IQ's less than 25 (profoundly retarded) while the IQ's of the remaining 16 patients ranged from 25 to 29 (severely retarded).

All behavioral medications were withdrawn during the two weeks prior to the study in order to establish a base line of behavior. During this period, nursing personnel recorded frequency and severity of seizures, need for restraints and the severity of the target symptoms. Aggressiveness, hyperkinesia, withdrawal, self-abuse, assaultiveness and temper tantrums were rated on a scale from 0-absent to 4-severe and these were entered on a chart devised for this study, as were the observations of the author who saw each patient at least once weekly.

At the conclusion of the period with no medication, patients were placed on one or the other of the study drugs. The starting dose was individualized for each patient, ranging from 25 mg. to 150 mg. thioridazine or chlorpromazine per day depending on the severity of the patient's symptoms and extrapolation of the dose of medication she had received prior to the study. The liquid forms were used, with dosage being adjusted as required for optimum control. The median dose for both drugs was 150 mg. per day; the maximum dose for thioridazine was 800 mg. per day (reached in 3 patients) and 600 mg. per day for chlorpromazine (reached in 2 patients).

Ratings for each patient were repeated weekly during the 8-week study. The severity of symptoms before and after treatment, the patient's general attitude and adjustment, her ability to partake in and cooperate with ward activities, the impressions of the attendants and medical staff and assessment of side effects formed the basis for a global evaluation of each patient at the conclusion of the study.

Results

The effect of the drugs on the six target symptoms at 2 weeks of treatment, 4 weeks of treatment and 8 weeks of treatment is shown in Table I, which shows that all target symptoms responded to treatment with the drugs, five of the six significantly so. Improvement with thioridazine appeared to be both more rapid and more intense

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* Lapeer State Home and Training School, Lapeer, Michigan

Table I
Average Improvement In Target Symptoms

Symptom	Drug	Week 2	Week 4	Week 8
Aggressiveness	Chlorpromazine	—0.023	0.071	0.324*
	Thioridazine	0.478*	0.465*	0.844*
Hyperkinesia	Chlorpromazine	0	0.321	0.304*
	Thioridazine	0.283*	0.328*	0.609*
Withdrawal	Chlorpromazine	0.182*	0.286*	0.217
	Thioridazine	0.261	0.259*	0.484*
Self-abuse	Chlorpromazine	0.046	0.214	0.130
	Thioridazine	0.087	0.034	0.141
Assaultiveness	Chlorpromazine	0.091	0.143	0.500*
	Thioridazine	0.609*	0.793*	1.109*
Temper Tantrums	Chlorpromazine	0.227	0.286	0.696*
	Thioridazine	0.456*	0.517*	0.969*

* denotes significant improvement over base line rating (probability value less than 0.05)
minus sign indicates worsening

The following between drug differences in improvement were significant (probability value less than 0.05):

Thioridazine superior to chlorpromazine:

Aggressiveness at weeks 2 and 8

Assaultiveness at weeks 2, 4 and 8

than with chlorpromazine. Thioridazine reduced aggressiveness, hyperkinesia, assaultiveness and temper tantrums for each of the periods, whereas chlorpromazine did not produce significant improvement in these symptoms until week 8.

Chlorpromazine produced a more rapid improvement in the target symptom of withdrawal, but this was not sustained. Thioridazine did not bring about significant improvement of withdrawal until week 4. Thereafter, the effect of the drug on this symptom became more pronounced, reaching its peak at the end of eight weeks.

Over and above these comparisons of each drug with its pre-drug levels, between-drug comparisons showed that thioridazine was more effective than chlorpromazine in the lessening of aggressiveness and assaultiveness.

The results of the global evaluation made at the conclusion of the 8-week study are shown in Table II, which excludes 5 patients dropped from the study because of intercurrent illness. Sixteen (57%) of the 28 profoundly retarded patients receiving thioridazine were considered improved, 9 (32%) unchanged and 3 (11%) worse. Fourteen (44%) of the 32 profoundly retarded patients recieving chlorpromazine were considered improved, an equal number unchanged and 4 (12%) worse. Among the severely retarded patients, 4 of the six receiving chlorpromazine showed improvement, as did 7 of the 9 on thioridazine.

Further evidence of the relative effectiveness of the two drugs was shown in the lessened need for restraints in both groups, 53% reduction in those receiving thioridazine and 10% reduction in those receiving chlorpromazine. This may be related to the alleviation of aggressiveness and assaultiveness.

Fifteen patients had a previous history of seizures and of these, 12 were treated with thioridazine and 3 with chlorpromazine. The incidence was low in all but two patients, both of whom received thioridazine and exhibited a reduction of seizure activity during the study. No patients experienced an increase in seizures.

Side effects were generally mild and self-limiting. Drowsiness of a mild degree was noted in one-third of the patients receiving thioridazine and in one-half of the patients on chlorpromazine (Table III). Ataxia and parkinsonism were somewhat

AUTHOR

Doctor Ucer is Chief of Psychiatry, Lapeer State Home and Training School at Lapeer.

Table II
Global Evaluation

	Profoundly Retarded				Severely Retarded				Totals			
Drug	No.	Improved	No Change	Worse	No.	Improved	No Change	Worse	No.	Improved	No Change	Worse
Chlorpromazine	32	14 [44%]	14 [44%]	4 [12%]	6	4 [66%]	1 [17%]	1 [17%]	38	18 [47%]	15 [40%]	5 [13%]
Thioridazine	28	16 [57%]	9 [32%]	3 [11%]	9	7 [78%]	1 [11%]	1 [11%]	37	23 [62%]	10 [27%]	4 [11%]

Table III
Side Effects

	Thioridazine	Chlorpromazine
Drowsiness	13	18
Hypoactivity	1	0
Ataxia	1	12
Insomnia	1	0
Muscular Weakness	1	0
Emesis	3	1
Dystonia	0	1
Dryness of mouth	0	2
Parkinsonism	0	6
Salivation, Drooling	0	2
Fatigue	0	1

troublesome with chlorpromazine. Moderately severe vomiting developed in four patients (3 thioridazine, 1 chlorpromazine) after two weeks of treatment. A change of dosage form, i.e., from liquid to tablets, caused disappearance of all gastrointestinal symptoms within 3 days. No physical cause for this condition was found on physical and X-ray examination.

Discussion

Both chlorpromazine and thioridazine proved to be of value in improving the behavior disorders in these retarded patients. This finding is in line with that of Badham, et al.[7] who described thioridazine as "effective in controlling disorders of behavior in a significant proportion of severely subnormal patients." In the study reported here, thioridazine was more effective than chlorpromazine in the extent of reduction of target symptoms and number of patients improved. In part, this may be the result of the better toleration for larger doses of thioridazine where required, as indicated by the fewer side effects it generated.

A concomitant result of the improvement obtained in this study was the improved order in the wards where the patients were housed. Patients seemed happier in their surroundings and there were fewer accidents, probably as a result of the reduced hyperkinesia and assaultiveness of the patients. This parallels the experience reported by Abbott et al.[8] who found that thioridazine's effect on more fractious patients led to a more reassured attitude in their cohorts.

Summary

A comparative study of chlorpromazine and thioridazine showed both drugs to be effective for the treatment of behavior disorders in mental retardates, as measured by improvement in target symptoms and a global evaluation. Thioridazine exerted a more rapid and intense effect on aggressiveness, assaultiveness, hyperkinesia and temper tantrums than did chlorpromazine. The increased benefit derived from thioridazine was attributable in part to a greater toleration, notably the reduced incidence of drowsiness, ataxia and Parkinsonism.

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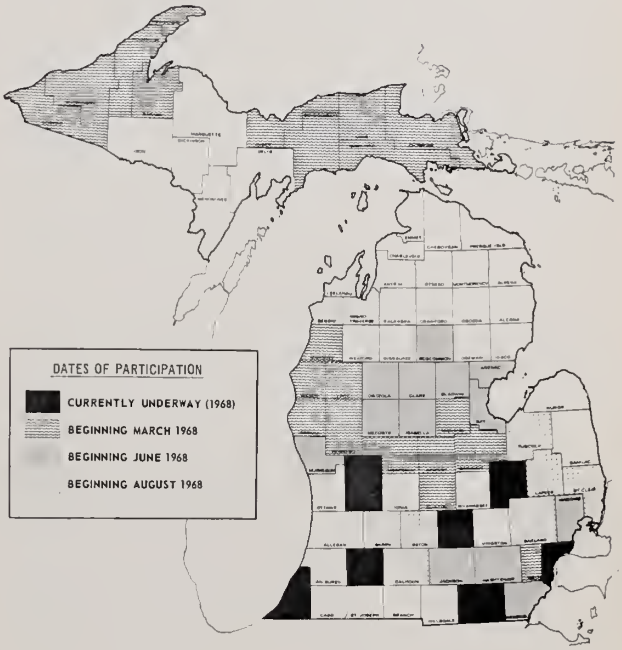
Progress Report on Project ECHO, Michigan's Continuous Health Survey

Editor's Comment: Many of the readers of MICHIGAN MEDICINE have had little opportunity to gain any knowledge of one type of government health program called Project ECHO. The authors of this article outline its purposes and explain the initial steps to attain those that have been taken in a Michigan area.—George H. Lowrey, M.D., Scientific Editor.

BY MAURICE S. REIZEN, M.D.
ROBERT F. LEWIS, PH.D.,
BOTH OF LANSING

HEALTH JURISDICTIONS TO PARTICIPATE IN PROJECT ECHO



Health is related to the way people live and to their surroundings. A program geared to improve the health of a people must, therefore, attempt to evaluate the prevailing ecological conditions and armed with this knowledge formulate changes for the better. Changes by neighborhood seems to be the approach most likely to succeed. By focusing on specific and current health problems, one can communicate with the residents and provide for cooperative program development involving local citizenry, governmental agencies at all levels, plus interested professional and voluntary organizations.

Project *ECHO* (Evidence for Community Health Organization) is designed to provide the foundation for such an approach and is specifically directed to community and neighborhood comprehensive health planning; ie. the relating of programs to documented needs and the marshaling of resources to meet these needs.

On the national scene, the direction and progress of health programs has been supported by information contributed by the U.S. Census and the National Center for Health Statistics. Consisting of interviews and medical examinations, appraisals of health facilities and services, evaluation of environmental conditions, etc., a series of reports has evolved giving an accurate profile of many aspects of the health of the nation, viz: The National Health Survey. However, national statistics have little relevance for an individual state or community, much less a neighborhood. And, to paraphrase the Folsom Report, "Health is a Neighborhood Affair."[1]

PROJECT ECHO WAS conceived in January, 1967, in an effort to determine whether a continuous health survey would be of value in providing answers to a multitude of questions. These queries were leveled at the Michigan Department of Public Health as well as local, state and national organizations, both within and without the framework of government.

The mechanics of this project take place at the local level. The collection, dissemination and utilization of information is the function of the local health department. Data is collected by local professionals — environmental specialists and public health nurses working in teams. This will give them first-hand knowledge of conditions within their community, thus enabling them to effectively communicate this intelligence to citizens and governmental leaders.

The function of the Michigan Department of

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[1] *Health Is a Community Affair*, National Commission on Community Health Services, Harvard University Press, Cambridge, Mass., 1966

Public Health in Project ECHO is to render technical service to local health workers. Thus, the Center for Health Statistics of the Michigan Department of Public Health makes available scarce professional expertise for local development, coordinated direction and objective interpretation of results. The Center provides statistical and computing services; provides technical and professional guidance in data collection and dissemination; processes and summarizes data; and maintains a single protocol of methodology by means of training and retraining of personnel in many local health agencies.

Many other divisions of the Michigan Department of Public Health also contribute their specialized services as required.

PROJECT ECHO WAS launched in 1967 for the following cities and counties: Benton Harbor, Kalamazoo, Grand Rapids, Lansing, Genesee County, Adrian and Detroit.

The map shows the other counties and areas that are scheduled to join the program in March, June and August of 1968.

Phases Involved in Project Echo

I. Environmental block appraisal, block mapping and block identification.

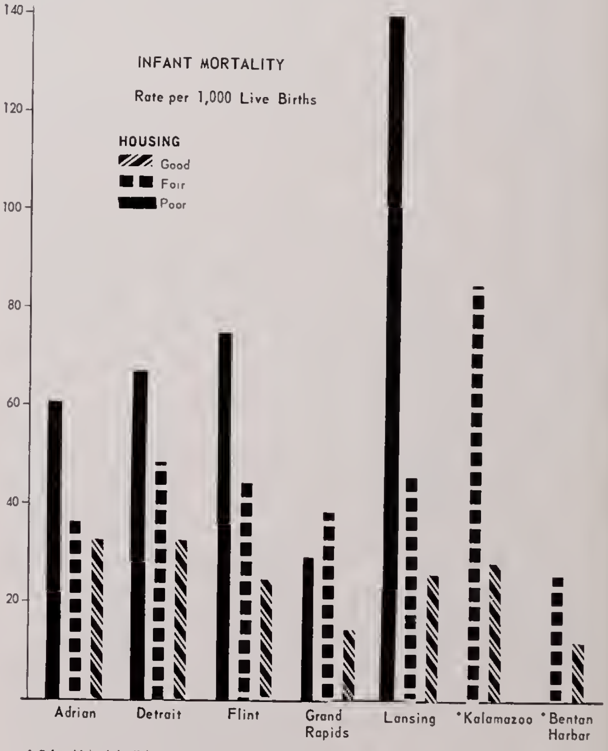
Project ECHO starts with a mapping phase whereby blocks are identified and form the basic reference filing system for all future data. Census tracts provide a useful framework, but are not necessarily the only method of designating a sample area. School boundaries, natural boundaries, and neighborhood areas may also be used. Work starts with a base of approximately 250 blocks, spanning areas both of degradation and relatively high quality. Each block is observed and a record made as to the quality of housing. A modification of the American Public Health Association method for evaluating the housing is used.[2, 3]

Each dwelling unit within the block is checked on the initial survey. The list of these units provides the basis for the sampling techniques to be used on subsequent visits. Population estimates can be made later which will lead to current estimates far more accurate than interpolation of outmoded census data.

The results of the external environmental appraisal of blocks is mapped and color-coded on the basis of good, fair, and deteriorated areas and forms the foundation for presentation of other data so that the relationship between geography, health indices and quality of environment can be delineated. Once completed, block reappraisal will be kept current by return surveys. The bar graph depicting infant mortality is based on information obtained from the pilot area in each community; and may change when more blocks are surveyed.

II. Health appraisal based on individual interviews with continuing probability sampling, together with an updating of dwelling unit listing and environmental changes.

Phase 2 involves obtaining specific health status information from *selected* households. From the listing of dwelling units obtained from Phase 1,



* Data obtained in Kalamazoo and Benton Harbor was insufficient in the poor-housing classification.

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2. *An Appraisal Method for Measuring the Quality of Housing,* Am. Public Health Assoc., Committee on The Hygiene of Housing, 1790 Broadway, 1945. New York, N.Y.
3. Waldrop, Reuel H., *Community Block Survey and Socioeconomic Stratification,* U.S.P.H.S. National Communicable Disease Center, Atlanta, Georgia, no date published.

the Center for Health Statistics provides to each jurisdiction a weekly sample of dwelling units. Three enquiries are made to each dwelling unit over a three-week period. in the first visit, the sanitarian reobserves the block for environmental changes, updates the listing of dwelling units, and also makes an appraisal of the interior. The nurse initiates a health interview which covers relatively superficially the family characteristics, chronic medical disorders and recent illnesses. The second and third visits are frequently conducted by telephone. Here, questions are asked concerning health situations, use of health services, additional recent illnesses and immunization status. It might be in order at this point to inform the reader that the confidentiality of this material is never broached and this is emphasized to the interviewees. As a result, the reception has been excellent to date.

The interview is intended to provide basic information on demographic characteristics, morbidity and use of health services, with intensive *local* inquiries to be handled as a special section, but using the ECHO sampling base. Information such as this is not available through any other means at present.

III. Dissemination of information to citizens, and local and state health agencies.

Phase 3 involves feeding the information back to the community. Here, the Center for Health Statistics will be responsible for processing, analyzing, and summarizing the information accumulated on a block-by-block basis. The material produced will be in response to what the nurse, sanitarian and local health officer request. Areas of concern are identified and the material may be presented via several different vehicles. Overhead projections, 35mm slides, spot maps, tables, etc., all have been used in one locale or another.

An additional dividend from the Center is the timely availability of statistical information previously stored but rarely utilized. Thus, spot maps have been produced on short notice noting the location by block of each case of tuberculosis, syphilis, neonatal mortality, deaths from heart, cancer, stroke, etc., for the use of concerned health departments and others.

IV. Neighborhood Action Programs.

From the local aspect here is where ECHO survives or goes by the wayside. The responsibility is squarely up to the local health agency. It may and should involve other units of government, lay and volunteer groups, but most vital to its success are the residents of the neighborhood itself. There is a significant aspect of ECHO apart from action programs and this is in the long term evaluation of the multiple problems that beset any community whether it involves solely the health department or not.

EXPERIENCE IN MICHIGAN and elsewhere has shown that neighborhood people are willing to put time and effort into appropriate health activities given the information and the motivation. Rat control, immunization procedures, baby clinics, infant mortality surveys, earlier prenatal care for the medically deprived are but a few of the issues in which a neighborhood can undertake action programs when given the proper stimulus.

At the present time, Ingham County is involved in all of the first three phases of Project ECHO. By the time this article goes to press, Phase IV will be underway. Presentation of the above material in detail has already been scheduled for

REIZEN

CO-AUTHORS

Doctor Reizen is Director of the Ingham County Health Department. Doctor Lewis is Chief, Michigan Center for Health Statistics, Michigan Department of Public Health, Lansing.

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interested church groups, governmental units, medical students, and neighborhood organizations.

Contemplated Long-term Results for Project ECHO

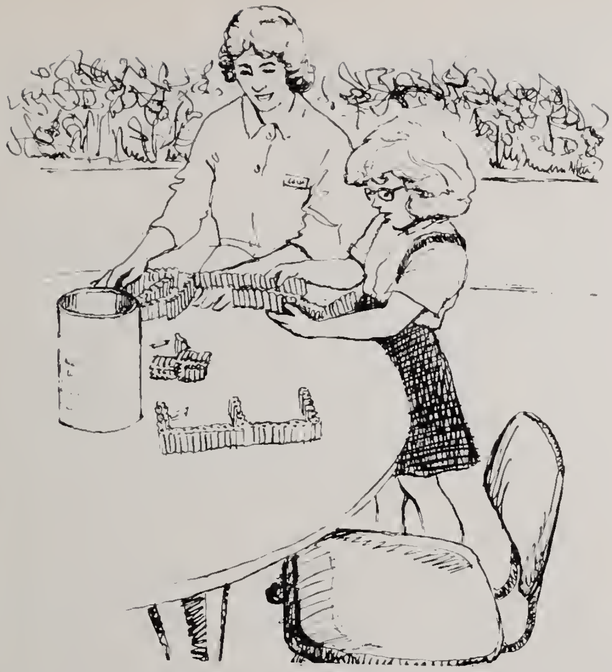
1. Current population estimates for any configuration of small areas at any time.
2. Current information about the health and the physical environment of the people of Michigan at any time or over any period of time.
3. Identification of the ways of life and the elements in the physical and social environment which appear to lead not only to illness, but to "well-ness," or to a positive state of health.
4. Identification of neighborhoods in which something can be done with present resources and a description of their characteristics which can lead to action programs precisely tailored to specific problems, including budgeting, timing, methods of organization and operation, duration, and anticipated results.
5. Positive evidence for the initiation of new programs and a reappraisal of existing programs for the various agencies involved in alleviating observed health problems.
6. Identification of geographic areas before they become extreme problems, as a guide to long range planning.
7. Observation of the rate of change in items of specific concern as a means of evaluating levels and types of programs.
8. Provision of vital statistics for individual localities in a way which is immediately useful for program operation.

Relevance To Practicing Physicians

The technique of Project ECHO has usefulness readily apparent to practicing physicians. Phase II, in particular can present information to the physician which has never been made available before, especially at the local level.

We will be able to furnish our colleagues with accurate information as to the immunization status of the area, the number of "miscarriages" that really occur in a year, the delivery of health services by whom and where located, etc. Other questions may be inserted into this viable survey and removed when no longer required. A separate section in the questionnaire has been provided for topics of local concern. These may very well be requested by the local medical society.

The majority of physicians we encounter have the subjective opinion that most of the people in their neighborhood are receiving good medical care. We strongly agree with this premise. Here is an opportunity to present evidence that the bulk of our population is truly receiving competent health services in Michigan. Item 3 under contemplated long-term results would also be of ultimate value to physicians. This is the identification of the positive factors in the "well-ness" of the population surveyed. What are the plus factors evident in our neighborhoods and how can they be transplanted to less healthy areas?



A rooftop patio for pediatric patients at the University Hospital at Ann Arbor was featured in the July issue of THE AUXILIARY LEADER, the journal for hospital auxiliaries. Made possible by the interest and contributions of a number of Michigan businessmen, the rooftop garden was formerly a drab concrete playcourt. Now it serves as a place for play and even outdoor picnics for the hospitalized children. It is furnished with flowers, trees, and shrubbery, and is manned by volunteers and hospital teachers who instruct and supervise the children in their games and schoolwork.

BOOKS RECEIVED BY MSMS

The Human Adrenal Cortex: its Function Throughout Life. (Ciba Foundation Study Group No. 27) Edited by G. E. W. Wolstenholme and Ruth Porter. 146 pp, illustrated. Little, Brown and Company, Boston, 1967.

Antilymphocytic Serum. (Ciba Foundation Study Group No. 29) Edited by G. E. W. Wolstenholme and Maeve O'Connor. 165 pp, illustrated. Little, Brown and Company, Boston, 1967.

Drug Responses in Man. (Ciba Foundation Symposium) Edited by G. E. W. Wolstenholme and Ruth Porter. 257 pp, illustrated. $13.00. Little, Brown and Company, Boston, 1967.

Myotatic, Kinesthetic and Vestibular Mechanisms. (Ciba Foundation Symposium) Edited by A. V. S. deReuck and Julie Knight. 331 pp, illustrated. $13.50. Little, Brown and Company, Boston, 1967.

Burns, Shock, and Plasma Volume Regulation. By Carl A. Moyer and Harvey R. Butcher, Jr. 428 pp, illustrated. $18.50. C. V. Mosby Company, Saint Louis, 1967.

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What Is Current Thrust of MSMS In Economics, Organization, MD Business Problems?

Where does MSMS stand regarding economics, organization, and business problems of private practice?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS. The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed any of the previous articles may wish to go back and read them. The following article is Chapter VI in the booklet.

Discussion

Environment of Practice

A full-fledged effort by MSMS is being conducted to attempt to gain some insight into the future environment in which medicine will be practiced and how medicne will be practiced in that environment. If this effort is reasonably successful, it can suggest guidelines which will permit Michigan medicine to have some influence on its own destiny.

Future Trends in Position Papers

An important side effect will be a broader knowledge of present and future trends by the many doctors who will read the position papers being obtained, thus building a membership more alert to and responsive to the society's planning.

Insurance and Other Factors Probed

Of necessity a great portion of this work will concern itself in the insurance area. Such factors as government involvement, supply and demand, rising costs, broader benefits, controls, awareness and involvement of the profession, etc., are being probed.

Health Economics Practice Economies

But while it is wrestling with the intricacies of the insurance mechanism, effects upon patient care, physician-patient relations, professional income, and doctor-to-doctor relationships, etc., both the broad extremes of health economics and the minutiae of practice economies need study.

Hospital Management Multiple Coverage by Insurance

Factors in hospital management and insurance often have marked effects upon patterns of practice. Automated record keeping, electronic patient monitoring, the establishment of therapeutic centers, home care, etc., will have an economic effect on the doctor. So will such things as the sale of multiple coverage of insurance, for people with multiple coverage use doctors and medical facilities more extensively.

Lower Cost of Practice Savings to Patient Efficiency Expertise

Thus, as adequate health care for all Americans becomes a public policy, the investigation of those economics affecting medical practice must be extended. But, again, these broad subjects cannot be permitted to be so overwhelming as to remove the necessity of seeking ways in which the medical doctor can lower the cost of practice and pass these savings on to the patient. Experts in the field of time and motion studies, for example, are working closely with dentists and apparently have been successful in saving professional time and some costs. Such studies might be infinitely more complex in the case of the various medical specialties and practices but nonetheless may be valuable.

Questions

A. What will be the effect on the private practice of medicine when health becomes the largest industry in the country (only agriculture and construction are larger today) ?	Health Third Largest Industry
B. What will the effect be of a doubling of the expenditures for health?	Larger Health Expenditures
C. What is the effect of health services on the economy at large ininsofar as prosperity is concerned?	Health Services and Prosperity
D. Can savings in the cost of medical care be gained if the comprehensive approach is used instead of the categorical approach?	Comprehensive Approach Less Costly Than Categorical
E. What would be the effect on the solo practice of medicine rendered on a fee-for-service basis if comprehensive programs providing a broad spectrum of services become more available?	Solo Practice and Comprehensive Care
F. What is the proper function of the outpatient department of a general hospital? What should it be in the future? What should be the relationship of the outpatient department of the hospital and the doctor's office? How should they compare?	Hospital Outpatient Department
G. A movement has begun to intergrate the community hospital (as a center of excellence) with extended care facilities to neighborhood centers and directly to the home through associated home care teams. What effect will this have on the private practice medicine? On the availability, cost, and quality of care received in the area covered?	Community Hospital Plus Neighborhood Centers Plus Home Care
H. Is there a noteworthy demand for a mechanism of prepaying for total medical and hospital care by a flat fee?	Flat Fee for Total Care
I. What place will closed panel direct service plans occupy in the future practice of medicine?	Closed Panel Direct Service Plans
J. What effect will future federal legislation have on group practice?	Legislation on Group Practice
K. What will be the effect on private practice and upon the confidential patient-doctor relationships if the physician personally supplies fewer and fewer of the services which are capable of being performed by personnel of lesser training?	Effect of Extended Health Team on Confidentiality
L. Would a time and motion study be valuable? 1. Of medical practice in the doctor's office? 2. Of medical practice by the doctor in the hospital?	Time and Motion Studies
M. Should a study be made of the probable influence of medical facilities—their nature, availability, and cost—upon the future practice of medicine?	Facilities and Medical Practice
N. What effect is the disappearance of medical indigence having upon 1. The income of the physician? 2. His patterns of charging for services? 3. His relationships with his patients?	Disappearance of Medical Indigence
O. What effect would changes (e. g., closed panel, group rates, comprehensive care) have upon 1. The quality of medicine the physician practices? 2. The professional standards he adheres to?	Effect of Changes

The New Look
In Social Security Disability Program

BY C. ARTHUR HAKENEN,
DAVID P. GAGE, M.D.
BOTH OF LANSING

Mr. Hakenen is Chief of the Disability Determination Service, Division of Vocational Rehabilitation and Doctor Gage is Chief Medical Consultant for the Division.

There have been significant changes recently in the disability provisions of the Social Security Act. In 1965 the definition of disability was revised to include "impairment which has lasted or can be expected to last for a continuous period of not less than 12 months." Thus the definition now includes temporary as well as long-term impairments. The applicant's impairment must, however, be so severe that it prevents him from doing any substantial work appropriate for his education, training, and experience.

The 1967 amendments provide benefits for disabled widows and widowers at age 50 on their spouse's Social Security account, if they have no insurance coverage of their own. The widow or widower must have become totally disabled before or within seven years of the spouse's death.

The new amendments also made special provision for workers who became disabled before age 31: they now have a liberalized earnings test which takes into account their relatively limited opportunity to have earned Social Security Coverage. Other disabled persons must still have worked under Social Security for 5 out of 10 years preceding the onset of disability. The Social Security definition of blindness has also been liberalized.

THERE ARE NOW three kinds of disability benefits to those who qualify: (1) disabled workers under age 65; (2) unmarried disabled children over age 18 of retired or deceased workers, if the child's disability began before age 18 and continues to prevent any gainful work; (3) disabled widows and widowers, age 50 or over.

In Michigan these claims are adjudicated by our Disability Determination Service—Division of Vocational Rehabilitation, under contract with the Social Security Administration. We process between 2000-2600 claims a month. The eligibility requirements are more severe than in most disability insurance systems; the denial rate in Michigan and the other states is around 33%.

Adjudication Process

Application for benefits is made in the local Social Security office, which advises the person about eligibility and evidence requirements. The applicant must supply at his own expense sufficient medical evidence to establish the presence of an injury or disease. The Social Security Office gives him medical report forms to take or mail to the treating physician or facility. To the extent that they are available in his patient's chart, the physician is asked to report the history with therapy and response, physical and laboratory findings, and the diagnosis.

PHYSICIANS SUBMITTING reports do not have to determine whether or not their patient

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Social Security Disability Provisions at a Glance:

** Benefits are payable to disabled persons under age 65 and their dependents.
** Worker is considered "disabled" only if significant impairment keeps him from doing any substantial gainful work suited to his education, vocational skills, and work experience.
** Benefits are payable if disability has lasted or is expected to last 12 months or result in death.
** Benefits last as long as disability continues, or worker returns to job, or until retirement benefits start.
** Claimants may get free rehabilitation services through the Michigan Division of Vocational Rehabilitation.

is "disabled," since this is the legal responsibility of the State Agency and Social Security.

When the medical and vocational evidence is in the file it is mailed to our Agency, where it is evaluated by a staff physician and a disability examiner trained in disability evaluation. The physician is responsible for assessing the severity, duration and remediability of impairment, as supported by the findings; the disability examiner considers the medical implications as they relate to the applicant's education, work experience, vocational skills and remaining work capacity. The team weighs all the evidence and arrives at a decision, which is signed by both members.

IF ADDITIONAL MEDICAL evidence is needed the Agency requests it from physicians, hospitals and clinics where the applicant received treatment. If not available from these sources our staff physician authorizes an independent medical examination, to document the file to the extent necessary for adjudication purposes; payment is made in accordance with the Michigan State Medical Society's own fee schedule for government agencies.

When our team completes its evaluation the file is sent to the central Social Security office for final review and action, to assure nationwide consistency in carrying out the law. Social Security also informs the applicant of the decision. Allowed claims are reviewed periodically to determine if disability continues, or if work capacity has been restored.

If the applicant is not satisfied with the decision, he has the right to appeal it. These levels include reconsideration of his claim, independent review by a Hearing Examiner, and judicial review in the Federal District Court.

Role of the Treating Physician

Medical evidence submitted by the attending physicians of this state continues to be more substantial and more objective, thus eliminating in many cases the need to send your patient for a consultative examination.

Not infrequently the State Agency might need an additional laboratory test or two in order to fully document the medical profile of the client and in such an instance we would prefer to, and do try to, obtain these from the attending physician.

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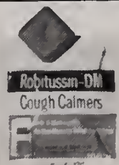

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SUGGESTIONS IN FEDERAL MANPOWER REPORT BRINGS REACTION FROM DOCTORS

Reactions were invited in the February issue of *Michigan Medicine* to the recommendations of the National Advisory Commission on Health Manpower. The Publication Committee again extends the invitation to MSMS members to voice their views of the many recommendations.

The February issue discussed some of the recommendations, and the subject was covered further by two speakers at the MSMS Conference on Health Planning in Detroit February 22-23. Comments of the speakers will appear in future issues.

Two MSMS committees are studying the new national report in detail, and the AMA Board of Trustees has several national committees looking hard at the recommendations.

Some medical leaders have expressed the opinion that these new national recommendations could well lead to more federal legislation in the medical-health field.

Following are some of the comments from MSMS members:

GEORGE T. KELLEHER, MD.
BATTLE CREEK

"The report of the National Advisory Commission on Health Manpower includes a recommendation that: professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care.

"Over ten years ago the Calhoun County Medical Society Committee on Third-Party Encroachment offered these Cassandran observations:

"Interest in third party encroachment is derived from the general feeling that interference is any proper transaction between two individuals by any third person or agency is improper not only because it is a trepass upon individual freedom of action, but, also because such transgression leads to direction of the transaction by the third party. In considering third parties as related to the medical profession and doctor-patient relationship, it is readily apparent that such intrusions, in transferring authority from doctor and patient, lead to control not only of the economic aspects of the relationship, but, inevitably to direction of the professional relationship, influence of the physician's judgements and treatments, direction of patients to physicians and physicians to patients and other forms of control of this formerly free relationship. The result, as has been seen elsewhere, is to convert the physician to a tradesman or technician and results in less efficient and pleasing patient care.

"Earlier the society had noted (April, 1957): —The appeasement of collectivistic groups in the past by the introduction of the service concept has actually been an invitation to them to continue the attack— The attack, obviously, has continued, and is continuing.

"At that time, it was pointed out that third party determination of whom is properly hospitalized means that the third party is, in fact, practicing medicine.

"In a mixed economy, such as has come to pass in this land, the constant push is by the collectivistic segments and each appeasement represents further victory in their drive toward complete political medicine.

"Organized medicine is obligated to engage in activities which improve the art and science of medicine. However, these activities proceed with the recognition that professionalism requires each professional to regard his peers (silly word—who anyplace, has a peer) as professionals, and accord to each the respect that reciprocates with the responsibility his fellow has accepted.

"Health insurance organizations and governments are not qualified to make patient care judgements and, consequently, should not participate in review procedures having to do with health care. Health insurance organizations should function as insurance organizations and insure against health care expense; some are interested in doing that—one insurance executive has disclaimed interest in health care by declaring, we are insurance men, not medicine men.

"The government has placed itself in the insurance business. If a patient wants to seek indemnification from this public carrier, let him so do; but, view this carrier as any other carrier—simply that and nothing more.

"As Dr. Wilbur has pointed out, if physicians were permitted to spend more time practicing medicine there would be less of a manpower problem. One way this might be accomplished is to eschew bureau-oriented activities unrelated to patient care which unnecessarily waste so much of the physician's time.

"The government might better serve us all if it directed some review procedures toward that peerless monoply, the U.S. Post Office; the cost of doing business with this non-competitive anachronism has doubled since 1958, and a study to develop its effective use might be labeled 'peerless review procedures.'

As Henry David Thoreau said in 1849:—"government never of itself furthered any enterprise, but by the alacrity with which it got out of it's way."

GORDON A. EADIE, M.D.
NEWBERRY

"The recommendation of the National Advisory Commission on Health Manpower which especially interests me is the one that states Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality. My comments are offered after a discussion with the staff of the local Helen Newberry Joy Hospital.

"It is well known, of course, that it is not easy to expand enrollment while improving quality in medical education and this has been one of the main road blocks toward increasing the number of medical graduates. I assume that the Commission's proposal to expand enrollment involves some sort of payment to the medical schools for each student enrolled or perhaps for each student beyond a certain minimum. On the surface this sounds like a desirable thing. It is well known that the major portion of federal support for medical schools has been in the form of research grants. These have little effect on student enrollment, therefore, some new approach would seem desirable.

"The other side of the coin, that of improving the quality of medical education could be stimulated through funds ear-marked for teaching staff salaries. Throughout the history of medical education the schools have had to depend largely for their instructors upon men in practice who draw most of their income from their practices. The wise use of Federal funds to pay full-time instructors would certainly help to answer this problem.

"While in agreement on the need for increased funds we must not overlook the equally important, if not more important, factor of the motivation of students. It is my strong conviction that the motivation of medical students to serve their

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CONTINUED: REACTIONS FROM DOCTORS

patients and to raise the health level of the United States, especially of those people in the poverty groups, needs to be strengthened greatly. It would certainly be helpful if funds could be available to the medical schools to employ instructors who will inspire the students in these directions.

"Our hospital staff also wanted to emphasize the need for more general practitioners. You are undoubtedly familar with the project whereby students from MSU worked in the Western U.P. Health District last summer. Much more of this kind of thing is needed and this would be a valuable use of Federal funds."

RICHARD R. GALPIN, M.D.
BIRMINGHAM

"You have invited comments to the recommendations of the National Advisory Commission on Health Manpower.

"With respect to the recommendation for Federal funds and support of operating costs of medical schools, I would feel that this is a reasonable approach, and one which I feel is inevitable if we are to achieve an adequate number of physicians to serve the country.

One of the recommendations deals with minimum educational standards for foreign-trained physicians. I feel here that one would have to be very careful in the difinition of foreign. Certainly physicians trained in class A medical schools in Canada and the United Kingdom should be differentiated from students who are trained in other areas. But in general, I feel that the standards required are reasonable.

To carry out the recommendation that The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates; one would have to be careful here not to infringe upon the citizenship rights of graduates other than Americans. This is an area which would be approached cautiously.

"I have no quarrel with the recommendations that studies be undertaken on the development of guidelines for state licensure codes. My comments again would be favorable to the proposal that studies be made of the possibility of periodic relicensing of physicians and other health professionals. In general, I feel that as much as possible these areas must be left if possible to state authority and carried out at the state level. There is no question that the Federal government will become more increasingly involved in these areas, but I do believe that matters of licensure, licensing review, accreditation, must be left at a state level if they are to be efficiently enforced."

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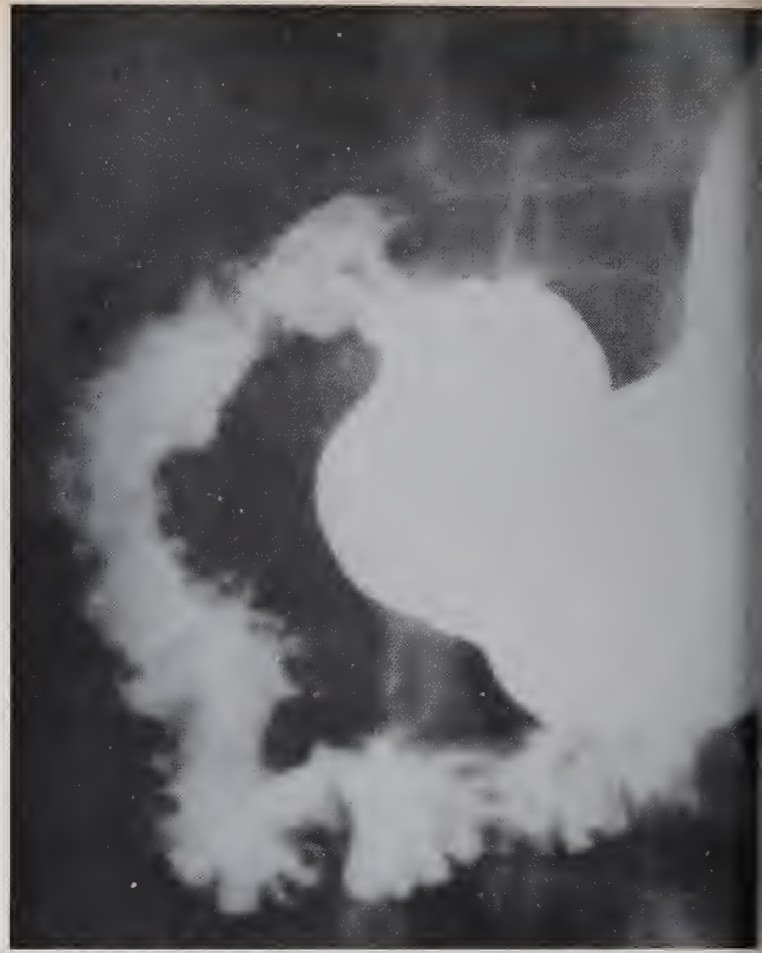

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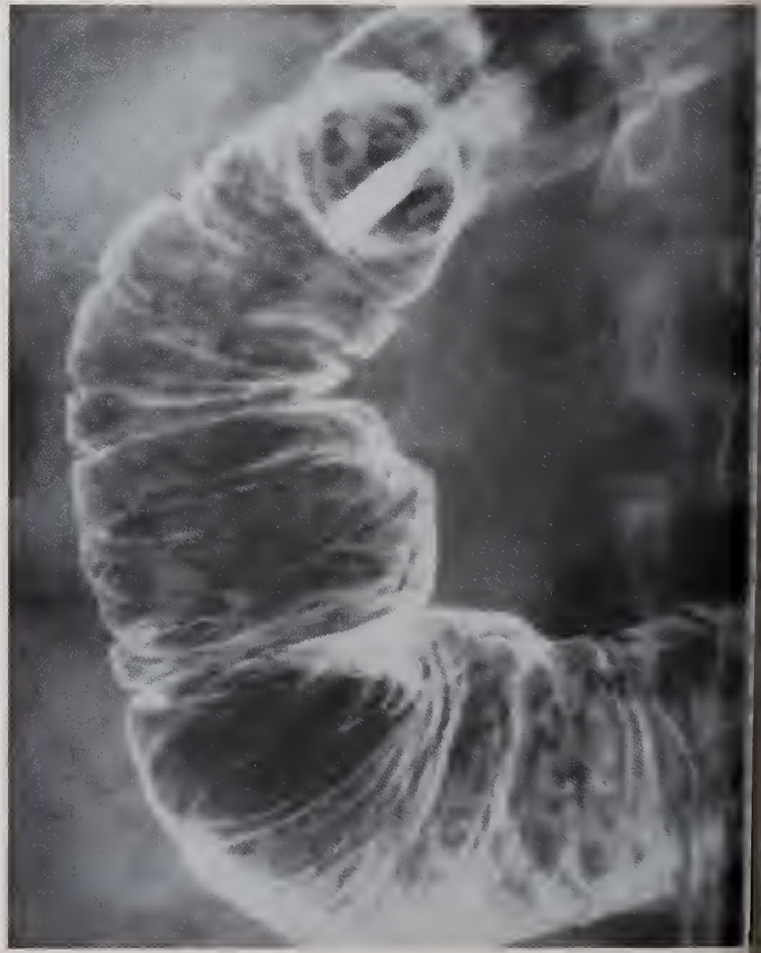

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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89:*438-443 (Sept.) 1967.

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Poison Prevention Campaign Shows Limited Success

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

Deaths caused by accidents are on the rise in Michigan. The most recent figures published by the National Safety Council indicate that the National figure for 1966 was 5% above that of 1965 and the figure for the state of Michigan rose by the same percentage.

Over the past six years, there has been a steady rise in the number of deaths in our nation caused by accidents. This is in contrast to the decade from 1950 to 1960 in which there was a slow but steady decrease from year to year.

PERHAPS MOST discouraging to the physician, where he feels that he has the greatest control, is the fact that fatal accidents in the home increased by 3% from 1965 to 1966. More than 2,000 of these deaths could be attributed to poisoning by either solids or liquids of which the largest classification are medicines.

President Johnson has designated that the week of March 17-23 will be Poison Prevention Week. What have we as physicians accomplished through our efforts since the first Poison Prevention Week was designated by an act of Congress in 1960? If statistics do not lie, we have accomplished very little indeed. In the year, 1966, 2,100 people lost their lives as a result of poisoning and this represents a 10 to 15% increase over 1960.

Although it is always difficult to evaluate figures, it does appear that the short but intensive campaign using pamphlets in physicians' offices, radio and television messages, and store window posters is a rather futile means of attacking the problem.

WITHIN THE PAST 10 to 15 years a large number of poison information and therapy centers have been established throughout the United States and Canada. At last count twelve such centers existed in the state of Michigan. It is a little discouraging to note that there has been no general downward trend in the frequency of accidental poisoning nor in the death rate resulting therefrom. Admittedly, part of the apparent reason for this has been the improvement in gathering statistics and the greater accuracy of reporting, but it would seem that some sort of plateau should be reached.

The physician can and must play an important role in this safety campaign but it must be emphasized that the individual must be repeatedly informed and instructed in order to make an effective program in preventive medicine.

The fact that 50% of the fatalities are due to medications should make the physician even more alert to the problem. Of all medications involved in these fatalities, aspirin leads the list. Tranquilizers and barbiturates are next in order.

Among other household products causing a high percentage of fatalities are cleansing agents, particularly those with solvents added. Not far down the list are poisonous plants of which a variety of mushrooms are the most frequently indicated in the northern states.

MORE THAN HALF of the fatalities occur in children under four years of age. This is an age group that must be protected, they cannot be taught to avoid potentially dangerous situations. It is up to the family physician to repeatedly stimulate parents to remove the danger as much as possible and to enforce discipline when necessary.

Two further important points for the doctor to remember are to prescribe only the amount of medication which is needed for a particular episode and thus reduce the number of leftover medications that may be found around the home. Secondly, he should always be very specific about the instructions in the use of the medication relative to the size and frequency of the dosage.

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Researchers Complete State School Finance Study, Offer Recommendations

Michigan physicians for many different reasons are interested in the recently-published *Michigan School Finance Study Summary Report,* published by the Michigan Department of Education. Following are some excerpts for doctors to study for their many viewpoints as parents, taxpayers, community leaders, opinion molders, etc.

The *Summary* booklet lists the following nine conclusions as "the most important" drawn from the research during the 15-month study:

"(1) While enrollments in the elementary grades show signs of leveling off, and secondary enrollment continues to grow, both adult education and pre-kindergarten enrollments have been expanding.

"(2) There is great variation in the educational opportunities available to students in the state of Michigan.

"(3) There exist critical problems in the financing of urban education. These problems demand adequate financial support from the citizens of the state.

"(4) In comparison with many other states, vocational education in Michigan is inadequately supported from state funds. Special education services are not available in certain parts of Michigan.

"(5) The present procedures for the financing of school construction are very costly.

"(6) The pre-constitution portion of the teachers retirement fund is presently in serious financial difficulty.

"(7) Although there has been progress in the reorganization of districts, problems of inequality in educational opportunity and inefficient operation are still in existence.

"(8) The procedures for distributing state aid to school districts are overly complex, and do not accomplish the purpose of equalizing educational opportunity.

"(9) A revenue crisis also faces Michigan's nonpublic schools. There is a proportional shift in the student body from nonpublic to public school enrollment."

IN JULY, 1966, the Michigan legislature, acting upon a request from the Michigan State Board of Education, appropriated $200,000 for a comprehensive study of educational finance. The State Board subsequently appointed J. Alan Thomas, Director of the Midwest Administration Center, The University of Chicago, to direct the study. During the study, a large number of individuals — both professional and lay — assisted in the provision of information. Nonpublic as well as public school authorities took part in the collection of appropriate data.

The emphasis of the study was on an examination of educational opportunities available to the youth of Michigan, and of the relationship of these opportunities to the financing of education.

FOLLOWING ARE SOME of the findings of the study:

"The most favorable educational opportunities (in terms of a number of factors identified in the study) are available to students who live in districts of (a) high per pupil state equalized valuation, (b) high expenditures per pupil for education, (c) large size as measured by an enrollment of over 5,000 students, (d) high social class in terms of levels of income, quality of residence, and a preponderance of higher status occupations.

"The city of Detroit shows a much larger proportion of oversize classes than the rest of the state. The other major cities and the out-state districts differ only slightly along this dimension. The need for additional school buildings in the major cities is demonstrated by the fact that a much larger proportion of their schools are reported as exceeding capacity than are those in the out-state districts.

"THE QUALITY OF HOUSING and the income of residents of an attendance area are associated with the offering of classes for talented children, and the provision of the newer programs in mathematics, biological sciences, and physical sciences. Again, "high social class communities" are much more likely to have language laboratories in their junior and senior high schools, and to have provision for such facilities as closed circuit television and student study carrels. Urban schools with large proportions of Negro students enrolled show achievement levels which are lower than the levels in white schools in the same cities.

"The best qualified teachers (in terms of degree preparation and certification) are employed in the Detroit Standard Metropolitan Statistical Area, while the least well qualified are in the northern parts of the state. Unfortunately, the northern parts of the state also appear, on the basis of the data, to have an inadequate program of in-service training for teachers. Since the average age of teachers in northern Michigan is the highest in the state and because such teachers took their training at an earlier period, there is a greater need for an adequate in-service program.

"The shortage of teachers and other qualified supporting personnel appears to be greatest in the more densely populated metropolitan areas. This finding can be explained in part by the greater quantitative needs for personnel in these regions, both in terms of total student population growth and in terms of the desire to provide a broader program.

"THE LARGEST SINGLE factor in determining how much will be spent on the education of any given child in Michigan is the state equalized value per pupil in the school district in which he resides. State aid may reduce disparities in expenditure level, but it does not eliminate them.

"Of the 2,375,432 children enrolled in elementary and secondary schools in Michigan in 1966-67, 338,450 (14.2 per cent) were attending nonpublic schools. (The national nonpublic enrollment also comprises slightly more than 14 per cent of all pupils.)

"There are particularly strong concentrations of nonpublic school attendance in four Michigan metropolitan areas. In the Bay City Standard Metropolitan Statistical Area, 39.6 per cent of all elementary pupils are in nonpublic schools. In Grand Rapids, the figure is 28.2 per cent; in Saginaw and Detroit over 21 per cent.

Financing of Education in Michigan

"There should be additional emphasis on the use of state financial aid for reducing inequalities in educational opportunity for Michigan's students: (a) The most effective means to equalize educational opportunity in Michigan would be through transferring the responsibility for collecting the "allocated millage" portion of the property tax for education from localities to state government. This might, for example, result in a state-wide property tax rate of 12 mills for education, with a corresponding decrease in local property tax rates. These funds, together with addi-

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tional state revenue, would be used to finance a basic educational program for public students throughout the state; (b) If this program is unfeasible, a second alternative would be to transfer the property tax on industrial property from local to state responsibility. This property would then be freed from the local property tax and placed on state tax rolls. Michigan would then add to the basic state support a per student amount equivalent to the yield of this tax."

Vocational — Technical Education

"Michigan will need to devote considerable resources over the next decade to the extension of programs of vocational-technical education. Since the amounts of money involved are significant, every possible effort should be made to avoid waste and duplication. This involves careful state planning for the location of facilities and for program development. (a) Ideally, vocational centers should be part of comprehensive high schools. Where this is not possible, these facilities should be shared with post-secondary institutions. In some parts of the state, the intermediate school district may appropriately be authorized to build and equip vocational education facilities, and to operate them."

"As of December 31, 1966, there was a total of 918 local public school districts. This was reduced to 743 by September 1, 1967. Of these 918 districts, only 534 provided K-12 programs. Furthermore, 427 of the K-12 districts were inadequate by the established criteria, since they had fewer than 2,000 students enrolled in K-12 programs and/or less than $12,000 state equalized valuation per resident student. Thus, only 107 local school districts in the state were considered adequate, according to the three-fold criteria of total program, minimum enrollment, and financial support established by the State Reorganization Committee.

"Today, with eighty-three counties, Michigan has sixty intermediate districts that include all of the operating local school districts in the state. The boundaries of the intermediate districts are no longer completely contiguous with county lines, since they are determined by the attendance boundaries of the constituent local school districts."

THE STUDY SUMMARY REPORT contains a summary of the policy recommendations presented to the State Board of Education. "For the most part, the recommendations are stated as alternatives, on the basis of which appropriate policy may be developed," the *Report* states.

Financing of New Construction

"A reform of the procedure for financing construction will probably lead to increased state participation in the provision of revenues for this purpose. Three alternatives, based on experience in other states, are suggested:

"Alternative 1. The School Bond Loan Program might be revised, through the addition of a forgiveness feature for school districts which are not able on the basis of a reasonable millage to repay their existing indebtedness in a given period of time, say, 20 years. This amendment should result in a reduction of interest rates, as well as of total interest costs. It should also be an important step toward improving the fiscal solvency of school districts.

"Alternative 2. A second alternative is the development of an equalization program for the support of school building construction. This program would be similar to that utilized for the financing of current operation, with the state share varying inversely with local taxpaying ability. In terms of equitable treatment of school districts, the state would share in the debt retirement costs of districts which have already constructed their facilities.

"Alternative 3. A third possibility is in state sharing in the amortization of the cost of classroom space. For example, if the per pupil cost of space is $2,000 and the average expected life of a school facility is 50 years, the annual cost of space is $40."

School District Organization

"It is recommended that a Commission be appointed to develop a master plan for school district organization in Michigan. A concerted effort should be made to reduce the number of school districts in Michigan to a point where education can be most efficiently provided throughout the state.

"The present number of intermediate school districts should be drastically reduced. A minimum of 25,000 students is needed for an adequate intermediate school district, although there may be exceptions, depending upon the density of population in the area served by an intermediate school district. However, since travelling specialists, equipped, where necessary, with mobile units, can be employed, geographic area need not be a deterrent to the development of adequately staffed intermediate units in the northern part of the state."

PHYSICIANS INTERESTED IN obtaining a copy of the Michigan School Finance Study Summary Report should write to Dale Arnold, Information Officer, State Board of Education, 407 Bank of Lansing Building, Lansing.

100 Candles for Kalamazoo Academy of Medicine; Early Days Recalled

The Kalamazoo Academy of Medicine celebrated its 100th Anniversary recently.

On January 8, 1868, six physicians of the village of Kalamazoo founded the Kalamazoo Medical Association because the previous local medical organization, which covered several counties, had become too unwieldly.

Thanks to the late L. N. Upjohn, M.D., minutes from the meetings during the association's first three years of existence have survived.

After his mother died in the 1920's, Doctor Upjohn found the handwritten notes in the attic of her home. He passed the notes on to his son, E. Gifford Upjohn, M.D., who has spent a great deal of time deciphering the notes.

A list of the charter members of the organization is not included in the early minutes, but "those present" entries indicate that the organization grew rapidly.

Medical fees were one of the early concerns of the association; a committee was soon established to draw up a list of recommended fees.

Some examples:

Office consultation (common cases) $1-3; special consultations, 3-10; night visits, double fee and double mileage; additional charges for medicine furnished; obstetrical attendance and delivery, $10; if complications, $15-50; amputations above the knee, $30-100, below the knee, $25-50; dressing wounds, gunshot or other, $3-20; for writing letter of advice, $2-5; for medico-legal opinion, $5-50."

Water pollution was an early concern of the group. On October 18, 1870, members unanimously resolved that the water in the creek near the Holley Water Works could not be used for drinking or cooking without danger to public health.

Meetings involved presentation of papers, study reports, social time and afterward, "an hour was pleasantly spent at the hospital board of our worthy president in partaking of the good things set before us."

Eleven years after its founding, the association changed its name to the Kalamazoo Academy of Medicine.

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BELOW in the article is a list of 128 Michigan communities seeking family physicians. AT RIGHT is a chart of 56 Michigan communities now registered for 134 specialists. Physicians seeking to locate in Michigan communities — and communites actively looking for physicians — are served through the MD Placement Service of the Michigan Health Council, 712 Abbott, East Lansing 48823.

Many Michigan Communities Registered With MD Placement Service of Health Council

As a service to the people of Michigan and the profession of medicine, the Michigan Health Council conducts the MD Placement Program under the guidance of the Michigan State Medical Society. Inaugurated in 1953, with less than 25 Michigan communities seeking assistance, the program has expanded rapidly as the need for doctors of medicine has grown. The Michigan Health Council currently has 128 communities that are seeking general practitioners.

UPPER PENINSULA: Calumet, Crystal Falls, Escanaba, Ewen, Hancock-Houghton, Iron Mountain, Ishpeming, Laurium, Marquette, Newberry, Rock, Saute Ste. Marie, Stephenson.

NORTH CENTRAL: Alpena, Atlanta, Boyne City, Cheboygan, Hillman, Gaylord, Lincoln, Mackinaw City, Mancelona, McBain, Onaway, Posen, Rogers City, Vanderbilt.

WEST CENTRAL: Alma, Baldwin, Barryton, Bear Lake, Big Rapids, Carson City, Cedar Springs, Cutlerville, Edmore, Evart, Fruitport, Grand Haven, Grant, Greenville, Hesperia, Holton, Howard City, Kent City, Lakeview, LeRoy, Manistee, Muskegon, Ovid, Portland, Ravenna, St. Johns, Scottville, Shelby, Whitehall, Zeeland.

EAST CENTRAL: Auburn, Bad Axe, Bay City, Byron, Caseville, Cass City, Coleman, Columbiaville-Otter Lake Area, Deckerville, Elkton-Bad Axe, Emmett, Flint, Gladwin, Hale, Lapeer, Lexington, Memphis, Metamora, Millington, Morrice, Mt. Pleasant, Port Huron, St. Clair, Sandusky.

SOUTHWEST: Albion, Allegan, Bangor, Baroda, Battle Creek, Benton Harbor, Buchanan, Burr Oak, Charlotte, Coldwater, Coloma, Decatur, East Lansing, Eau Claire, Fennville, Galesburg, Grand Ledge, Hastings, Hillsdale, Holt, Jackson, Jonesville, Kalamazoo, Lansing, Litchfield, Marshall, Mason, Paw Paw, Plainwell, Potterville, Quincy, St. Joseph, Sturgis, Tecumseh-Adrian, Waldron.

SOUTHEAST: Ann Arbor, Detroit, Grosse Pointe Woods, Milford, New Haven, Romeo, Royal Oak, Saline, Sumpter Township, Troy, Whitmore Lake, Ypsilanti.

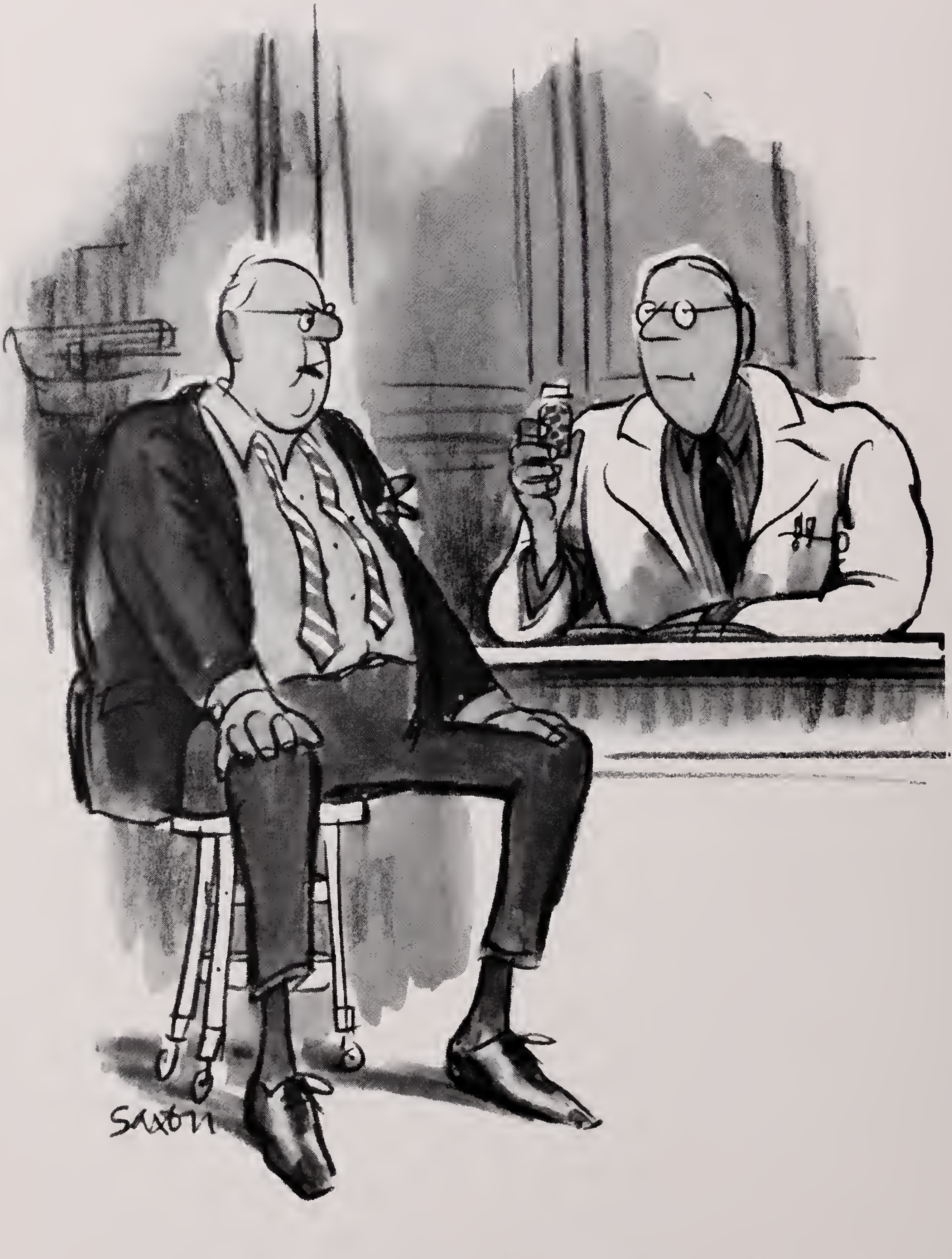
Medical specialists also are in great demand in Michigan. Fifty-six Michigan communities now are registered with the Michgan Health Council's Placement Service, some needing only one additional specialist, others seeking several physicians in the same specialty and/or a wide number of medical specialties.

The Council is working with 33 communities that are seeking internal medicine specialists, 12 that are seeking psychiatrists and/or neurologists, 11 that are seeking surgeons and 16 that are seeking pediatricians. In addition to the 133 specialty openings listed, there is a need for a rheumatologist in Grand Rapids.

For more information concerning the openings, write or phone:

John A. Doherty, Executive Director
Michigan Health Council
P. O. Box 431
East Lansing, Michigan 48823
Phone: 337-1615

	Anesthesiology	Dermatology	Ear-Nose-Throat	Industrial Medicine	Internal Medicine	Ob-Gyn	Ophthalmology	Orthopedics-Orthopedic Surgery	Otolaryngology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Research	Surgery	Urology	Rheumatology
UPPER PENINSULA																			
Calumet				X															
Crystal Falls					X														
Escanaba							X	X		X								X	
Hancock-Houghton			X		X			X				X						X	
Iron Mountain																	X		
Ishpeming-Negaunee					X			X				X							
Marquette		X	X											X					
Newberry														X					
Sault Ste. Marie			X		X	X	X					X							
NORTH CENTRAL																			
Alpena					X			X				X							
Charlevoix					X												X		
Gaylord					X														
Lake City													X						
Traverse City													X						
WEST CENTRAL																			
Alma	X					X											X		
Grand Haven					X			X	X					X				X	
Grand Rapids									X										X
Greenville					X	X											X		
Ionia														X					
Manistee					X		X	X				X						X	
St. Johns					X														
West Branch													X						
EAST CENTRAL																			
Flint													X						
Gladwin					X												X		
Lapeer					X							X							
Mt. Pleasant			X		X	X						X	X	X			X		
Owosso						X												X	
Port Huron																	X		
St. Clair					X												X		
SOUTHWEST																			
Albion					X		X												
Allegan													X						
Battle Creek					X									X					
Benton Harbor										X		X							
Buchanan												X							
Coldwater					X		X						X						
Fennville					X	X						X					X		
Galesburg					X														
Hastings					X							X							
Hillsdale					X		X											X	
Jackson			X		X		X		X			X		X					
Kalamazoo					X												X		
Lansing					X									X					
Marshall					X							X							
Mason						X													
Niles					X			X											
Paw Paw					X							X					X		
St. Joseph					X				X			X		X					
SOUTHEAST																			
Dearborn				X															
Detroit				X	X	X							X	X					
Howell					X														
Livonia						X													
Madison Heights			X				X		X			X							
Northville														X					
Pontiac													X	X					
Royal Oak					X														
Wayne					X														
MISCELLANEOUS																			
State-Wide Listings				X							X					X			
TOTALS	1	1	6	4	33	9	8	7	5	2	1	16	9	12	0	1	11	6	1



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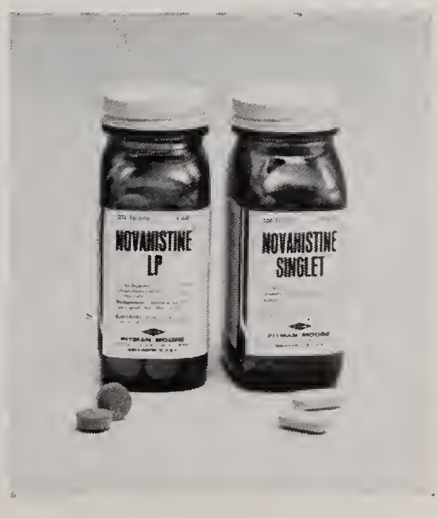

MHA Survey Confirms Rising Labor Costs

A survey of hospital statistics graphically illustrates the critical need by Michigan hospitals for new sources of capital to relieve the costs versus income squeeze, according to Allan Barth, executive director of the Michigan Hospital Association.

"Probably the most critical problem currently facing Michigan hospitals is where to find capital for much-needed improvements to facilities and equipment," Mr. Barth said.

He pointed out that because of the time required for reporting and tabulating the statistics, they include only the first indications of the impact of Medicare, Medicaid, the federal Wage-Hour Act and other governmental influences on rising hospital costs.

Mr. Barth said the statistics are compiled in an annual study of Michigan hospitals that also includes data collected from 33 Michigan osteopathic hospitals which are surveyed by the Michigan Osteopathic Hospital Association.

THE STUDY REVEALS that hospital operating expenses continued to increase more rapidly than total revenue, leaving the hospitals with a surplus of less than one-half of one percent to be used in meeting depreciation of facilities and equipment. This is the equivalent of only 25 cents per patient day.

While operating expenses rose to $363,624,000, voluntary non-profit hospitals took in $365,407,000 in total revenue, an increase of slightly less than $45 million over the previous year. This total revenue figure includes such items as grants, gifts, rentals, concessions and other non-patient payment sources.

Income from patient and third-party payments to Michigan voluntary hospitals in 1966 came to $350,572,000. Based solely on patient revenues against expenditures, the hospitals suffered a deficit of $13,052,000 or an average of $1.85 per patient day.

There was a 10.3 percent increase in hospital expenses per patient day in voluntary, short-term general hospitals. Costs increased from $47.64 in 1965 to $52.56 in 1966.

THE LARGEST PORTION of hospital expenditures was for payroll, which comprised 62.5 percent of overall hospital expenses in Michigan

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institutions. Nationally, the average total expense per patient day was $48.32 with payroll making up 61 percent of the total.

In the overall survey of statistics from 293 hospitals compiled by the Michigan Hospital Association, 151 were in the category of voluntary, short-term general care. These institutions and the hospitals included in the psychiatric group have 73 percent of the state's hospital beds and admitted 66 percent of the patients in 1966.

Other information obtained from the hospitals in their responses to the survey included:

— Admissions throughout the state showed a rising trend in 1966, with a total of 1,333,025 and a daily census of 67,944 patients as compared to 1,299,148 and 67,823 in 1965.

— Births in Michigan showed a slight increase in 1966. The total number of births in 1966 was 165,794, a rise of 311 over 1965.

— The ratio of full-time hospital employees to patients in Michigan voluntary, short-term hospitals was 268 required for every 100 patients. This represents an increase of 11 employees per 100 patients over 1965. A major factor in this increase can be attributed to staff increases necessitated by handling of Medicare claims.

— Payroll continued as the largest single budget item for voluntary hospitals, constituting 62.5 percent of the overall budget. For all hospitals, payroll expenditures amounted to 66 percent.

— Voluntary, short-term general hospitals accommodated more than 65 percent of all the persons admitted to Michigan hospitals in 1966. Osteopathic hospitals accepted just under 12 percent of all patients admitted.

— The average stay of Michigan voluntary hospital patients was 8.1 days, compared to the national average for these hospitals of 7.9 days.

— On the average, for every dollar spent in providing patient care in Michigan's non-profit general hospitals, 4.0 percent was for housekeeping; 10.1 percent for dietary; 3.6 percent for pharmacy; 1.4 percent for medical records; 1.6 percent anesthesiology; 6.9 percent for laboratory; 5.8 percent for radiology; 13.8 percent for administration and general supervision; 0.6 percent for inhalation therapy; 5.0 percent for medical surgical and intern-resident services; 5.0 percent for plant operations; 2.4 percent for laundry and linen services; 30.3 percent for nursing service, education, operating room and delivery; and 0.5 percent for other expenses such as social services, blood bank, ambulance, out-patient services and depreciation.

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Editorials Praise Efforts Of MSMS in Various Fields

Every week, Michigan newspapers voice their editorial opinions about various medical and health subjects.

Often these editorials deal with the need for physicians and often they describe efforts of the medical profession to recruit toward this same common goal.

Following are excerpts from several editorials which appeared recently:

The *St. Joseph Herald-Press* is one of the many Michigan newspapers to join the efforts to recruit more doctors. A recent editorial told its readers that, "Gifted young people of ability will find a life of work in the medical arts highly rewarding, spiritually and materially. Those who enter this field should dedicate themselves to maintaining the high standards that the profession has established."

The fine performance by Michigan doctors in international programs was lauded in the Michigan Mirror column which many newspapers print each week. The following are excerpts from the column as it appeared in the *Novi News*:

"Michigan doctors have an outstanding record contributing their services around the world. Only California, where more doctors are licensed, can match it.

"The Hope hospital ship, which visits countries inviting it, has 31 physicians and two medical students from Michigan on its staff. For this volunteer service, medical personnel receive no pay, and only moderate living expenses.

"Ill and injured Vietnamese are cared for by a separate program sponsored by American Medical Association and supported by the Michigan State Medical Society. Eight Michigan doctors are currently working in Vietnam to help fill the gap left by their need for military service. Vietnam has only 1,000 in the whole country and 650 of these are in the Vietnam army. The remaining 350 care for the country's 15 million civilian population.

"American physicians receive $10 per day living

Say you saw it in Michigan Medicine

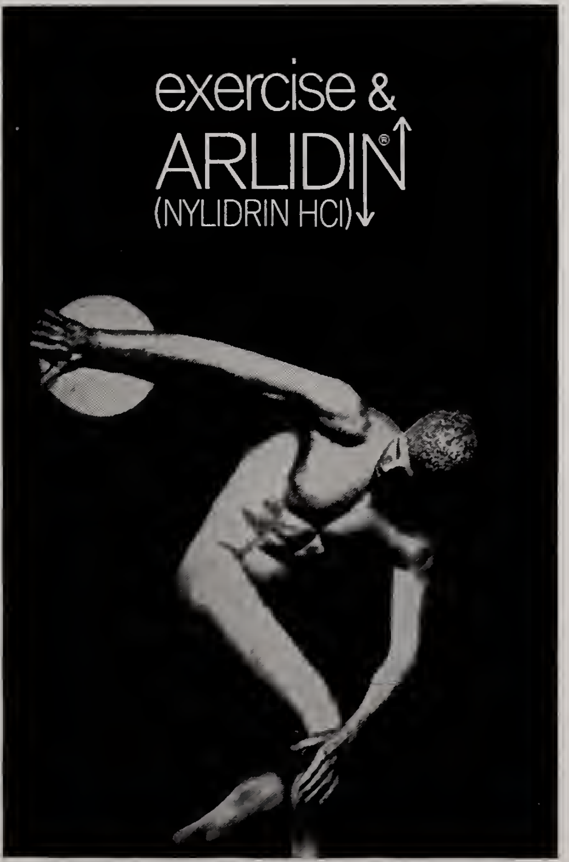
expense, and travel expenses to and from Vietnam. They serve for two-month periods in one of the 16 provincial hospitals.

"MEDICO is another plan which involves Michigan physicians overseas. It is administered through CARE. Six doctors from the state participated in MEDICO in Asia and Africa.

"Charles H. Moseley, M.D., director of the AMA plan, explains, 'This program has done more to improve the image of the American physician than any I know of. The Vietnamese people know that a physician who closes his office and comes as a volunteer to their land is making a sacrifice for them.' "

"Times are indeed changing. Integration in the health professions as between medical doctors and osteopaths is beginning"; so stated an editorial in the *Adrian Daily Telegram.*

The editorial described the action of the MSMS House of Delegates to permit osteopaths to apply for associate membership in county medical societies. The Adrian paper observed that "the long-standing feud in the medical profession between the medical and osteopathic physicians is easing." The editorial noted that MSMS "has opened its doors to the osteopaths."



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he said
gingerly.
(COMPLIMENTS OF
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ɛlp clear up that miserable stuffed-up ɛling with Dimetapp. Each hard-workg Extentab brings welcome relief from e stuffiness, drip and congestion of upper spiratory conditions for up to 10-12 urs. Yet, patients seldom experience owsiness or overstimulation. The key to ccess is the Dimetapp formula: Dimeıe (brompheniramine maleate)—along th phenylephrine and phenylpropanolaıne, two time-tested decongestants. They t the job done...in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

A.H. ROBINS COMPANY
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ı sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

ɪnetane® [brompheniramine maleate], 12 mg.;
ɪnylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

p to 10-12 hours clear
reathing on one tablet

If hypothyroidism leaves your patient feeling like this...

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LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy

Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

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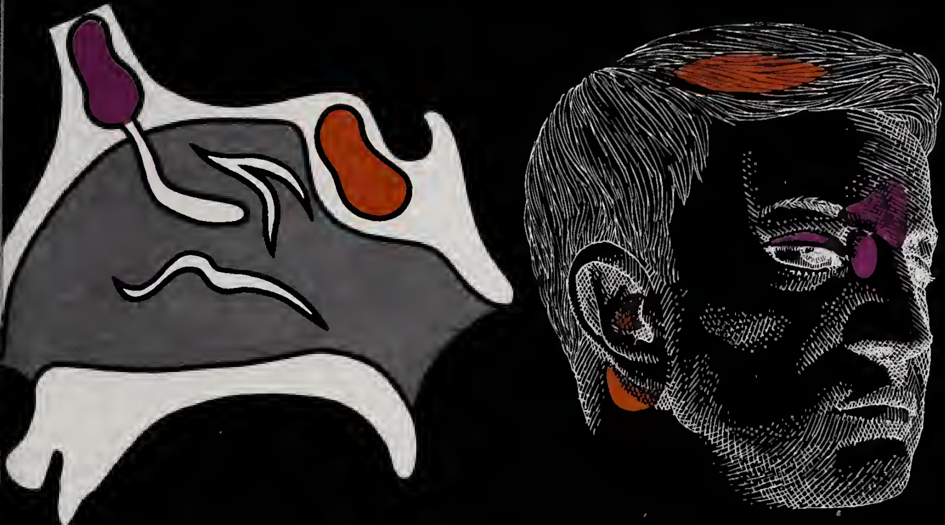
Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY · CHICAGO, ILLINOIS

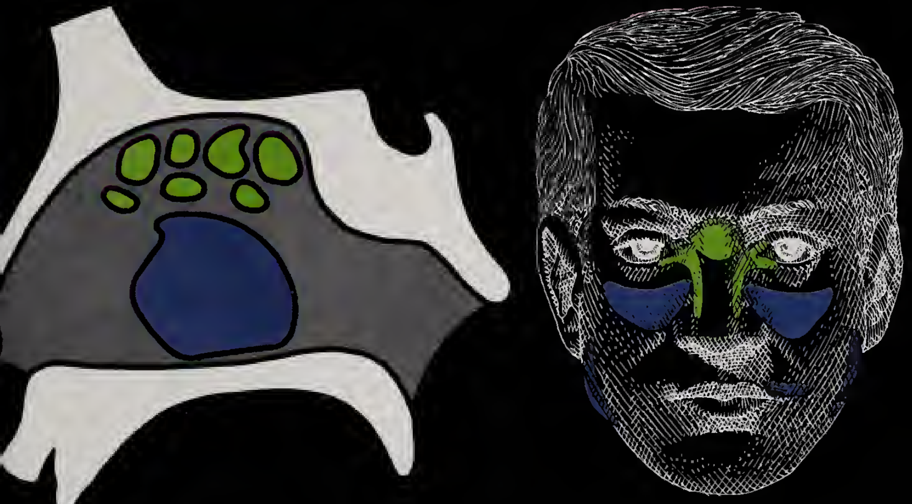
Sources of sinus headache



REGION OF SENSATION

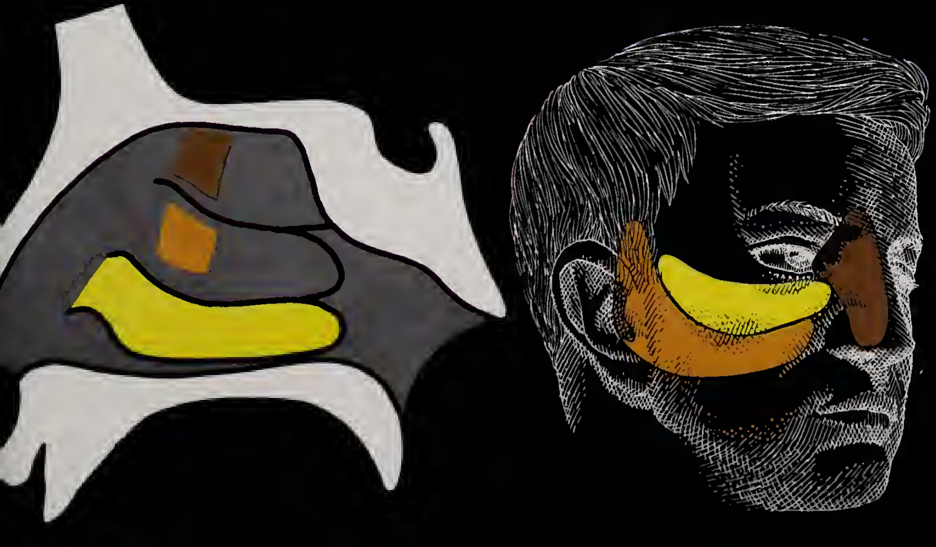
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA
SINUTAB®
FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

WARNER-CHILCOTT Morris Plains, N.J.

New Asset Management Plan for MSMS Approved by Delegates in Special Meeting

The MSMS House of Delegates, in special session February 14, adopted the recommendations of the MSMS treasurer to reorganize the MSMS financial structure; and then took action also to amend the bylaws and to authorize the MSMS Council to mortgage the headquarters building.

The special session was called by Speaker James B. Blodgett, M.D., upon the request of the MSMS Council to consider the recommendations of the Treasurer John R. Ylvisaker, M.D., to revise the management of MSMS assets.

IN HIS OPENING comments, Doctor Blodgett explained that, in September, the 1967 House of Delegates Reference Committee on Ways and Means had recommended approval "in principle" of the suggestions offered by Treasurer Ylvisaker. The MSMS Council, Doctor Blodgett reported, studied the recommendations further at two fall meetings and obtained statements from attorneys and tax consultants. Then the Council Finance Committee approved the recommendations as did the Council. The Council then asked that the special meeting of the House "be called prior to March 1, 1968 to consider the Treasurer's report," to specifically authorize implementation of the plan.

Doctor Ylvisaker, in his presentation, stressed that the new asset management program "cannot and will not avert dues increase or assessment if increase in future operation places such demands on MSMS."

In advocating a mortgage Doctor Ylvisaker pointed out that "it spreads this debt over the useful life of the building and apportions its costs progressively to succeeding current members."

DURING THE DISCUSSION, there was some opposition voiced to the proposals by delegates who expressed a different philosophy on finances.

In making the motion to adopt the Treasurer's proposals, Paul T. Lahti, M.D., Oakland delegate, declared, "For MSMS to be effective, we must have a sound, progressive financial program."

Doctor Lahti then moved that the Treasurer's report be adopted and approved; and further that the Council implement these recommendations immediately and expeditiously."

THE MOTION WAS carried after a roll call vote.

After the House adopted the revised MSMS asset management plan Speaker Blodgett adjourned the first meeting and invited delegates to confer with a special bylaws reference committee. The House was called back into session for its second meeting, and the reference committee report to adopt necessary changes in the bylaws was approved. The House then approved a motion to make the necessary changes to provide for the implementation.

FINAL ACTION OF the afternoon was a specific motion to authorize the MSMS Council to mortgage the building and proceed with the necessary legal instruments.

The meeting was held at the Wayne County Medical Society headquarters.

After the Council completes the mortgage on the building, the Council is authorized as part of the House action to establish three fund categories. One will be the Operational Fund, another will be a Capital Reserve Fund for contingencies and replacement of depreciable fixed assets, and the third will be a Managed Investment Fund to provide for extended service to the public, MSMS, component societies and the members.

THE FIVE GENERAL objectives of the Treasurer's plan, as outlined by Doctor Ylvisaker, are as follows:

"1) The retirement of current expenses out of current income (a positive rather than a negative cash flow position).

"2) The proper management of debt both by securing such debt for the lender and amortizing the amount within the Society budget and with progressive scheduled long-term retirement based on membership participation in the benefits which the debt has purchased for the Society.

"3) The provision of funded reserves adequate to protect the Society against demands caused by recurring predictable capital needs as well as unpredictable contingency needs.

"4) The establishment and intitial funding of a service reserve or trust, the income and growth of which may provide resources for a positive service program consonant with the purposes and responsibilities of the Society.

"5) The proper management of money derived from dues: a) To provide fixed dollar amounts sufficient to meet fixed dollar needs; b) To protect the purchasing power of dollars designated as long-term reserves; c) To achieve maximum income stability and growth where possible to protect the members against unwarranted additional cash demands either as dues or assessments."

WCMS Honors WSU; Check Aids Stapleton Reading Room

The Wayne County Medical Society, at a special program on February 5, sponsored an evening celebration in honor of Wayne State University School of Medicine on it Centennial Anniversary.

A highlight of the evening was the presentation of a check for $31,000 from the Wayne County Health Foundation and individual members of the Wayne County Medical Society for the Doctor William J. Stapleton Reading Room which will be part of the new medical library at the WSU new medical center.

Donald N. Sweeny, Jr. M.D., president of the Wayne County Health Foundation, presented the check to Edward M. Varden, M. D., president of the Board of Trustees of the Medical Library Fund.

Later in the evening, four talks were given on "A Historical View of the School of Medicine, Wayne State University." Alfred H. Whittaker, M.D., of the Wayne State University Board of Governors, outlined "The First Fifty Years"; Vice-President Gordon H. Scott, Ph.D., spoke on "The Last Fifty Years"; Dean Ernest D. Gardner, M.D., discussed "The Present Picture" and President William R. Keast, Ph.D., took a glance into the future with a talk on "The Next Fifty Years."

Chairman for the evening was Don W. McLean, M.D., with Frank B. Bicknell, M.D., president of Wayne County Medical Society, presiding.

BEGIN PG SERIES, MAR. 14, OAKLAND U.

A series of seven lectures on "Recent Advances in Clinical Physiology" will begin Thursday, March 14, 7:15 PM, in the Science Building at Oakland University for all interested physicians.

Topic of the first lecture is "Salt and the Kidney," by Arthur Vander, M.D., associate professor of physiology at the University of Michigan.

Complete details are available from Kenneth Meade, Director, Postgraduate Professional Education Programs, Oakland University, Rochester.

The MSMS Legal Affairs Committee meets many times at MSMS during each session of the Michigan Legislature to review the scores of health bills in terms of Society policies set forth by the house of Delegates and Council. Some of the Committee are pictured in a typical working meeting.

Medicine-Religion Workshop, March 27

"A physician knows what faith can do in the total health care of a patient. Often, in dark moments, it becomes as powerful as the most potent vaccines, as impressive as the instruments of modern medicine in restoring the blessings of health," said Winslow G. Fox, M.D., Chairman of the MSMS Committee on Medicine and Religion, in discussing the importance of a medicine and religion workshop in East Lansing, March 27.

Chairmen of county medical society medicine and religion committees have been invited to participate at the MSMS Headquarters.

Doctor Fox, of Ann Arbor, will give the welcoming address in the morning session. Paul B. McCleave, L.L.D., Director, and Robert L. Coons, both from the AMA Department of Medicine and Religion, will also speak to the participants in the morning.

Luncheon speaker will be Leroy Augenstein, Ph.D., chairman of the bio-physics department at Michigan State University.

In the afternoon, a series of dialogues or moral and ethical issues facing doctors today will be held. Among the topics are: Do DNA synthesis and heart transplants change our view of life? Does man have a moral right to die? What about the exchange of information between a doctor and clergy? Family Life Education; drug addiction and hallucinogens.

Committee Rosters Available From MSMS

Physicians interested in obtaining copies of the MSMS Committee Rosters can write to the MSMS Headquarters, P.O. Box 152, East Lansing 48823.

Careers Mobile Rolls March 15

The Health Careers Mobile, containing new exhibits which outline the health curricula at Wayne State University, Michigan State University, and the University of Michigan, will move to Mercy College in Detroit, Friday, March 15.

Sponsored by the Detroit Commission on Youth, the Health Careers Mobile will serve as part of a "Youth Conference on Health Careers" for all public and parochial schools in Detroit. The unit will remain at Mercy College for weekend viewing by students and the public.

After the Mercy College visit, it will begin a tour of Southeastern Michigan, including Dearborn, St. Clair Shores, and Birmingham.

In April and May, the Health Careers Mobile will participate in Healthoramas at Northland, Eastland, and Westland, in Detroit, sponsored by the Women of the United Foundation.

MSMS Group Going To AMPAC Rally

The AMPAC Board of Directors will hold its annual workshop in Washington, D.C., on March 9-10. The workshop will be aimed at the development of successful and effective candidate support committees at the congressional district level.

Attending from Michigan will be Vernon Bass, M.D., Frank B. Bicknell, M.D., E. J. Geist, M.D., Robert J. Frank, M.D., James J. Lightbody, M.D., and Ralph T. Wills, MSMS staff.

One of the featured speakers will be Frederick Van Duyne, M.D., of Flint, Republican chairman of Genesee County. He will discuss "Opportunities Unlimited."

120 Attend District SAMA Event at MSU

Students from 10 medical schools discussed new approaches to medical education and problems of health care at an SAMA regional meeting February 2-4 at Michigan State University.

Hosting the conference was the MSU chapter of SAMA, with financial support from the Ingham County Medical Society and other organizations.

MED ASSISTANTS TO MEET APRIL 21

The Michigan State Medical Assistants Society will hold its 11th Educational Seminar at the Pick-Durant Hotel, Flint, April 21.

Ethel Lundgren, seminar chairman, announces that the theme of the day will be "Medicine and Law."

Ground Broken by WSU For Basic Science Building

The groundbreaking ceremony for the Basic Science Building of Wayne State University School of Medicine was held February 14 at the Medical School campus.

When completed, the $24 million structure will be the largest state building ever constructed in terms of both cost and size.

A teaching and research facility, the Basic Science Building will be located at the southeast corner of Canfield and Brush in the new Medical Center complex.

The structure will help to permit WSU to increase its entering class from 125 students to 200.

The Basic Science Building will house the departments of anatomy, physiology, pharmacology, biochemistry, microbiology, and pathology, as well as administrative and service facilities.

Student study areas will include sections equipped with calculators, typewriters, and fixed microscopes. A television studio with facilities for color or black-and-white production will be located on the first floor. Closed circuit television will link student classrooms with work going on in area hospitals.

Total cost of the new Medical Campus, covering some 25 acres, of which the Basic Science Building will be a significant part, is estimated at $56 million.

Henderson to Chair U-M Ophthalmology Unit

John W. Henderson, M.D., an ophthalmologist on the University of Michigan faculty since 1945, was named chairman of its department of ophthalmology Friday, (Jan. 19). On July 1, he will succeed Doctor Bruce Fralick, who is retiring after 40 years of service. Doctor Henderson was the unanimous first choice of a faculty committee which searched throughout the United States and Canada for a new chairman.

Doctor Henderson, a native of Clarinda, Iowa, is a graduate of Occidental College and the Northwestern University Medical School. He was trained as an ophthalmologist at U-M by Doctor Fralick. He also studied neuroanatomy at U-M and was awarded a doctor of philosophy degree in that field in 1948.

Sweeny Named to Chair New AMA Committee

Donald N. Sweeny, Jr., M.D., Detroit, has been named chairman of an AMA ad hoc committee to work with a joint conference committee set up by the National Association of Blue Shield Plans and the American Medical Association.

Highlights of January 24 Council Meeting

The Council authorized two officers to attend as official representatives the 1968 Upper Peninsula Medical Society meeting in June.

Dates for the 1968 mid-summer session of The Council were approved, July 28-31.

MSMS approved a request for it to co-sponsor with the Michigan Hospital Association a meeting for physicians, administrators, and trustees, to discuss physician-hospital relations.

The Council named Robert E. Rice, M.D., Greenville, as Delegate, and Brooker L. Masters, M.D., Fremont, as Alternate Delegate to the Michigan Health Council.

MSMS authorized the following representatives to attend meetings: 1968 Association Public Affairs Conference, State of Michigan's Director's Annual Conference with Local Public Health Directors. AMA 64th Annual Congress on Medical Education, AMA Regional Workshop for State Chairmen of Committees on Medicine and Religion, Institute of Medicine of Chicago "The Doctor and His Hospital" Workshop, American Association of Medical Society Executives Orientation School for new Medical Executives and the AMA 21st National Conference on Rural Health.

The Council received a detailed report of the AMA Conference on Health Care for the Poor, submitted by Paul T. Lahti, M.D., who attended the Conference as MSMS representative.

The Council provided direction to the Legal Affairs Committee re Chiropractic Legislation.

The report of Michigan Medical Service presented by John M. Wellman, M.D., Chairman of the Board, discussed (1) operations, (2) building plans, (3) staff appointments, (4) alternate negotiations and new Blue Shield programs, (5) utilization review, (6) government program changes and (7) physicians participation.

The Council's Publication Committee heard a report on Journal Advertising and other details regarding the publication of *Michigan Medicine.*

Speaker James B. Blodgett, M.D., reviewed plans with The Council for the Special Session of the House of Delegates.

Minutes of the following committees were received with thanks and recommendations contained therein approved with amendments: Awards, Mental Health, Liaison with State Board of Registration in Medicine, Legal Affairs, Cancer, Aging, Eye Care, Alcohol and Drug Dependence and Committee on Rehabilitation.

The following elections and appointments were made by The Council: Kenneth H. Johnson, M.D., Secretary; John R. Ylvisaker, M.D., Treasurer; George H. Lowrey, M.D., Scientific Editor; Brooker L. Masters, M.D., Assistant Secretary; C. Allen Payne, M.D., Assistant Treasurer; Hugh W. Brenneman, Executive Director; and Warren F. Tryloff, Assistant Executive Director.

STACK RECEIVES JAYCEES AWARD

Jack Stack, M.D., of Alma, was recently selected as one of the "Five Outstanding Young Men of Michigan" by the Michigan Jaycees at their winter meeting in Saginaw.

"Many of our cynical friends question the validity of contributing a large segment of one's energies to community service to partisan politics, and to professional organizational responsibility," commented Doctor Stack upon receiving the award.

"My reply to them is that if I and not willing to participate in the search for the solutions to the problems of the times then I have relinquished this privilege to others who are willing to become involved," he continued.

"If I am not pleased with their solutions to the problems I shall have no recourse nor any right to criticize," Doctor Stack said.

"If my children grow up and find this society an undesirable world in which to live they will ask me what I do to protect it and to improve it for them and I must be able to answer, 'I did the very best I could,' " the Alma physician continued.

"I believe that we must be involved in the action and passion of our times or we shall run the risk of being judged not to have lived," he concluded.

Barnard Gives Galens Lecture

The South African surgeon who performed the world's first human heart transplant, Christian Barnard, M.D., gave the annual Galens Lecture at the University of Michigan.

Doctor Barnard spent March 6 at the medical school in a round of discussions and visits with students and faculty members.

From Ann Arbor, Doctor Barnard went to the University of Minnesota where he had taken medical training.

"The inconvenience of a cold"

cold, NTZ® Nasal Spray provides rapid relief of symptoms. Relief starts with the first spray which s the inferior part of the common meatus. A second , a few minutes later, will shrink the turbinates to provide sinus drainage and ventilation. Dosage pe repeated every three or four hours as needed, mporary relief of symptoms. NTZ is well tolerated verdosage should be avoided.

sinusitis deterrent, NTZ Nasal Spray can be used to the nasal passages open during a cold to help pre- development of acute sinusitis—or to help prevent cute condition from becoming chronic.

lied: NTZ Nasal Spray, plastic squeeze bottles of l.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

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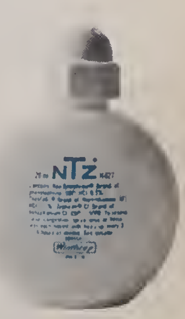

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Valium® (diazepam)
useful adjunct for the coronary patient...

When oppressive feelings and psychic tensions are severe and cooperation with the physician poor, it may be helpful to add adjunctive Valium (diazepam), 10 mg or 5 mg t.i.d., to the coronary patient's regimen. Valium (diazepam) helps to promote the needed relaxation that the patient requires to make him less preoccupied with his condition and more inclined to cooperate in, and benefit from, the total therapeutic program. Valium (diazepam) may be administered in the presence of secondary depressive symptoms.

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(5 mg or 10 mg t.i.d.)

convalescing...

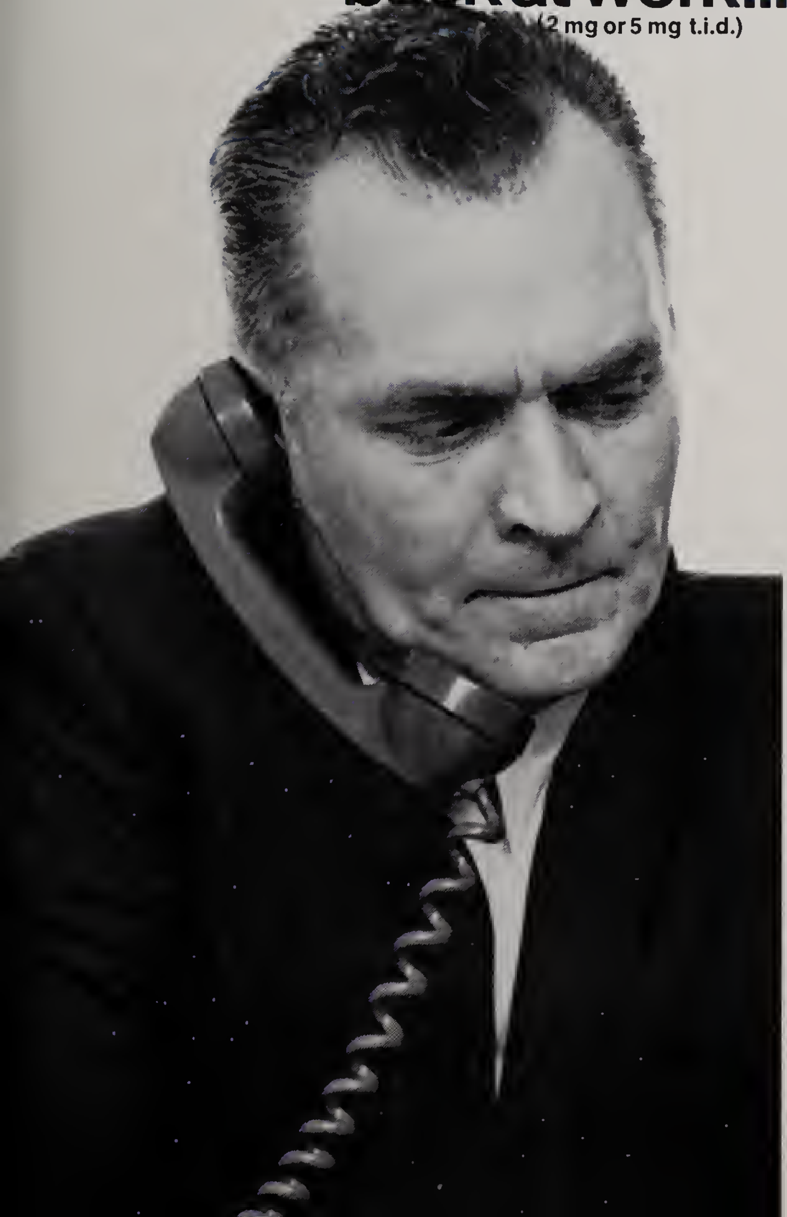
(2 mg or 5 mg t.i.d.)

The heart patient who leaves the hospital to enter a period of slow restorative treatment is often forced to make emotionally difficult adjustments. The resulting stress of this period may again cause psychic tension to mount to potentially harmful levels. To augment your reassurance and the emotional support of his family, a 2 mg or 5 mg t.i.d. regimen of Valium (diazepam) can reduce psychic tension and thereby help the patient to accept necessary restrictions more calmly, and to adjust to his illness more realistically.

Getting back to work presents additional stresses for the cardiac patient. There are often anxiety-producing features in the job which can be more significant than the physical or intellectual demands of the work. Valium (diazepam), 2 mg or 5 mg t.i.d., may be a useful adjunct to reduce overreaction to these stresses and thus help the patient to face job situations more calmly and rationally.

back at work...

(2 mg or 5 mg t.i.d.)



Valium® (diazepam)

to help relieve psychic tension

and for the patient with tension-induced sleeplessness, remember the value of an extra tablet at bedtime

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, moderate to severe psychoneurotic states with anxiety, apprehension or agitation alone or with depressive symptoms; somatic complaints which are concomitants of emotional factors; acute agitation due to alcohol withdrawal; muscle spasm associated with cerebral palsy and athetosis.

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d.

Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

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a puzzle
of antacid
complaints

"Will this one
taste O.K.?"
Will it help "my
gassy stomach?"
"Will it stop the pain?"

Mylanta®
aluminum and magnesium hydroxide *plus* simethicone

a solution
to peptic ulcer
distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

WSU Med Alumni Conclave May 15, Special This Year

The Golden Anniversary celebration of the Wayne State University School of Medicine's class of 1918 will be held May 15 at the Sheraton-Cadillac Hotel in Detroit.

Sponsored by the WSU Medical Alumni Association, the day will include a clinical section and a banquet in the evening celebrating the 100th anniversary of the founding of the medical school and honoring the class of 1918.

The clinical meeting will be held from 8:30 a.m. to 4:30 p.m. The banquet is at 7:00 p.m.

GENERAL THEME OF the day will be "Human Sexuality and Modern Marriage." Two of the speakers will come from the Bowman Gray School of Medicine in Winston Salem, North Carolina. Clark Vincent, Ph.D., Director of the Behavioral Sciences Center and professor of sociology, will speak on "Human Sexuality: A General View." Robert Coombs, Ph.D., assistant professor of sociology, will discuss "Acquired Sex Attitudes and Information — Role of Home and Parents."

"Changing Sexual Expectations in Women — The Special Role of the Physician's Wife," will be the topic of Peter Martin, M.D., clinical professor of psychiatry at Wayne State University's Medical School.

Speaking on "Marriage and Sexual Problems in Modern Society: An Overview of Pre-Marital and Marital Counselling" will be Richard H. Klemer, Ph.D., professor of family relations at the University of North Carolina in Greensboro.

"Psychodynamics of Teaching Medical Students Sex Education" will be discussed by Harold Lief, MD, professor of psychiatry and director of the division of family study, University of Pennsylvania, Philadelphia.

"I think the topic is very important in the light of the so-called sexual revolution," said Mario Petrini, MD, President of WSU Medical Alumni Association.

"THE PROGRAM SHOULD be helpful to the private practice physician," continued Doctor Petrini, "because more and more people are bringing their sexual problems to him and the physician is often poorly prepared to counsel people in this area."

"I would like to emphasize," Doctor Petrini added, "that the program this year is designed for doctors and their wives. Also we plan to invite other professionals who are involved in this field."

After five talks are given throughout the day, speakers will get together for a late-afternoon panel question and answer period.

DURING THE BANQUET in the evening, a special citation will be given to Duncan J. McColl, MD, of Port Huron. Doctor McColl will be 100 years old this year. He is the oldest living alumnus (1893) of Wayne State University and was born the year in which the Medical School was founded. Doctor McColl was named Michigan's Foremost Family Physician in 1954 by MSMS.

Coming in June

Once a year, the physician has an opportunity to spend the better part of a week doing nothing but "keeping up" at the world's largest medical meeting, the Annual Convention of the American Medical Association.

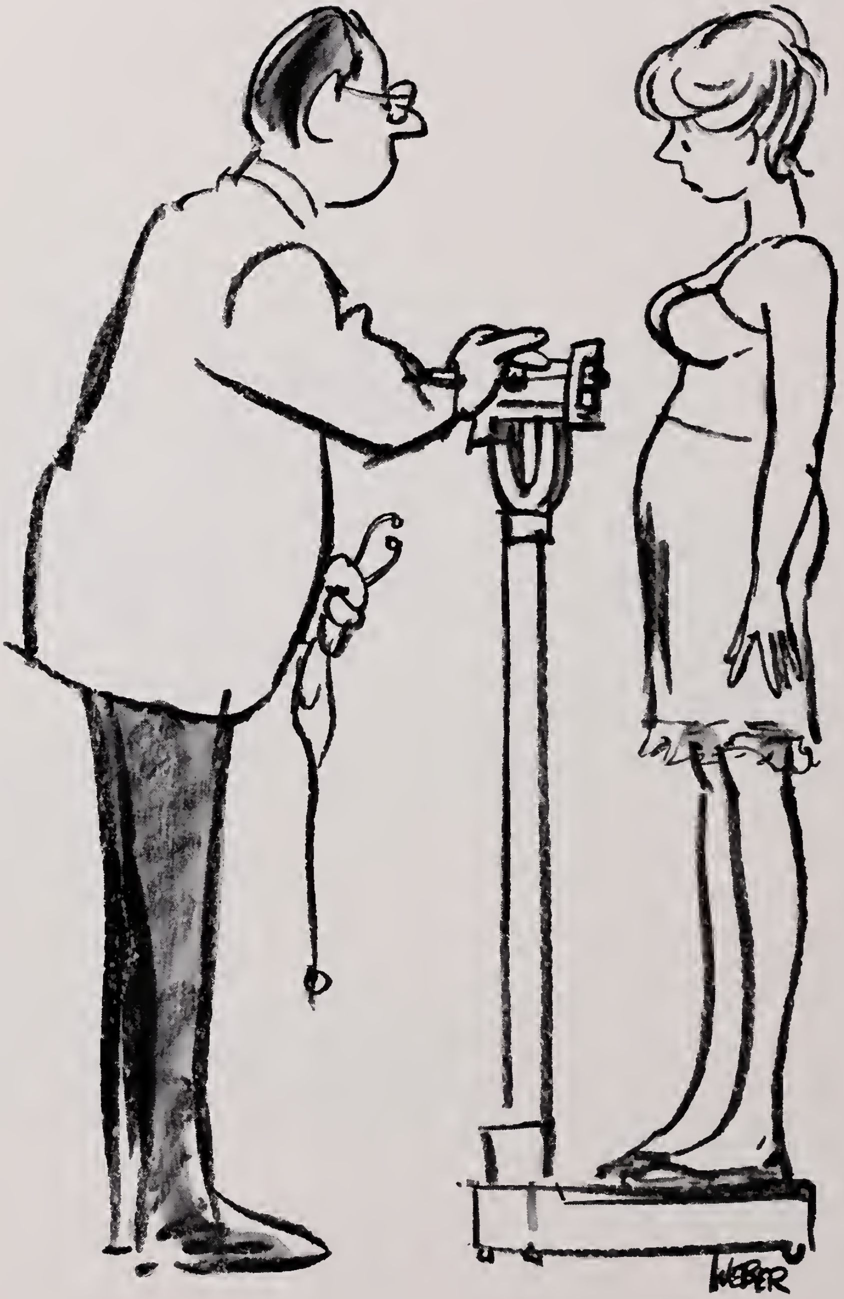
The 117th Annual Convention of the AMA will be held June 16-20 this year in San Francisco. The Civic Auditorium, War Memorial Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advanced malignant disease.

Four General Scientific Sessions will be presented and the 23 Scentific Sections will offer programs individually, many holding joint meetings on subjects of common interest.

A full schedule of medical motion pictures is planned, as is a program of live color telecasting from a San Francisco-area medical center.



"You're up ten pounds since your last physical. We're going to have to do something about that."

Say you saw it in Michigan Medicine

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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HORNE TO ADDRESS MATERNAL WELFARE CONCLAVE, MARCH 26-27

One of the major addresses, which will have a high public and physician interest, at the Seventh Annual Conference on Maternal and Perinatal Welfare in Flint, March 26-27, will be a discussion of "Infertility," by Herbert W. Horne, Jr., M.D., from the department of Obstetrics and Gynecology, Harvard Medical School, Brookline, Massachusetts.

Doctor Horne is presently doing research on population problems, population control, and infertility. Before beginning his practice in infertility, he was a research Fellow with John Rock, M.D.

Chairman for the morning session of the conference on March 26 is William W. Jack, M.D., Grand Rapids, immediate past chairman of the Committee on Maternal Health of MSMS. Banquet chairman is James E. Harryman, M.D., Muskegon, present chairman of the committee.

The cocktail hour this year at 6:00 p.m., March 26 is being sponsored by Ortho Pharmaceutical Corporation of Raritan, New Jersey. Ortho will sponsor an exhibit at the conference called "Rhogam."

Another exhibit which will be on display is "Perinatal Pathology" by Arch Brown, M.D., of Flint.

There is no registration fee for the conference and all physicians and interested persons are invited. A complete program of speakers and topics may be obtained from MSMS headquarters, P.O. Box 152, East Lansing.

MEDISCENE

March 6 — The Council, MSMS Headquarters, East Lansing

March 12 — State Woman's Auxiliary Legislative Day, MSMS Headquarters, East Lansing

March 13-14 — Annual meeting of the Michigan Academy of General Practice, Sheraton-Cadillac Hotel, Detroit

March 17-23 — National Poison Prevention Week

March 26-27 — Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 1 — 47th Annual Beaumont Lecture by Jose M. Delgado, M.D., Wayne State Medical Society Headquarters, Detroit, 8 p.m.

April 17 — The Council, MSMS Headquarters, East Lansing

April 21 — Eleventh Educational Seminar of MSMAS, Pick Durant Hotel, Flint

April 22-25 — Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

April 23-28 — 17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

April 30-May 1 — Woman's Auxiliary Spring Conference, MSMS Headquarters and Kellogg Center, M.S.U., East Lansing

May 1 — Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8 — Mental Health Week

May 4 — Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 8-10 — Michigan Public Health Association, Inc., Annual Conference, Jack Tar Hotel, Lansing

May 10-11 — Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 10-11-12 — 9th Annual Congress of the Professions (MAP), Boyne Highlands

May 15-18 — International Science Fair, Detroit

May 18 — Kresge Eye Institute Clinic Day, Detroit

May 18-19 — Pediatric Clinic Days

May 22 — Annual Muscle Symposium, Wayne County Medical Society, Detroit

June 5 — The Council, MSMS Headquarters, East Lansing

June 28-29 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 25-26-27 — MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 11-15 — American Public Health Association, Cobo Hall, Detroit

WSU TO OFFER SYMPOSIUM SOON ON ALCOHOL METABOLISM

A symposium on "Biochemical and Clinical Aspects of Alcohol Metabolism" will be sponsored April 11 and 12 by the Wayne State University School of Medicine. The two-day program will be held at the headquarters of the Wayne County Medical Society, 1010 Antietam.

Twenty five presentations will be made by physicians and scientists from 17 universities, laboratories, and hospitals in the United States and Canada.

In addition to seven clinical studies, the program will cover: determination of alcohol, alcohol dehydrogenase, metabolic effects of alcohol (experimental) and effects of alcohol on tissues and organs.

OTTAWA SPONSORS SERIES OF PUBLIC SEMINARS

The last in a series of three public medical forums sponsored by the Ottawa County Medical Society is scheduled for April 23 at the Holland Civic Center.

C. Mark Vasu, M.D., of Grand Rapids, will serve as moderator on the topic of "Medical Emergencies."

After the formal presentation, specialists in various fields will answer questions from the audience.

The first public forum in the series was on "Cancer," January 23. The second discussed "Heart Disease and High Blood Pressure," February 27.

The Year Ahead

In making an appeal for auxiliary members to recruit new members and to increase their participation, Mrs. Stanley J. Roman, President of the Woman's Auxiliary to the Wayne County Medical Society, wrote some thought-starter copy in a recent issue of the *Detroit Medical News.*

In part, Mrs. Roman said to the auxiliary members:

"We must respond as a unified group to the needs and problems of the medical profession which exist as a result of ever changing times.

"Today medicine is buffeted on all sides from the rocky shoals of public criticism to the turbulent waters of federal legislation.

"To allay this buffeting and thereby create a better public image, concerted effort will have to be drafted and inducted more than heretofore.

"We should listen to the advice and suggestions of lay people, but respond willingly, by clarifying, interpreting and expressing the philosophy and ethics of a profession whose purpose lies solely in being of service to the minds and bodies of all."

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"COCA-COLA" AND "COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY.

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Take a relaxing break for Coca-Cola. Couple of times a day. Because Coke has the taste you never get tired of. It's always refreshing.

Judicial Commission To Elect Officers Soon

The MSMS Judicial Commission, which met recently with three new members, will meet on April 17 to elect officers for 1968-69.

Robert H. Hamburg, M.D., Detroit, and W. H. Huron, M.D., Iron Mountain, both newly-elected to the Judicial Commission, were present at the last Commission meeting at MSMS.

Also present was Norbert W. Scholle, M.D., Muskegon, who was appointed to fill the vacancy created by the resignation of Carl B. Beeman, M.D., Grand Rapids. Doctor Scholle was appointed to serve until the next election of judicial commissioners.

At the meeting, Chairman Donald N. Sweeny, Jr., M.D., Detroit, was authorized to appoint a special subcommittee to evaluate and make recommendations for possible improvements in the present appeal procedures to the commission in matters of ethics and grievances.

EASTER SEAL CAMPAIGN TO BEGIN MARCH 1

Crippled children and adults in all 50 states, Puerto Rico, and the District of Columbia, will be given treatment and rehabilitation as a result of the 1968 Easter Seal Campaign which begins on March 1 and ends April 14, Easter Sunday.

Sumner G. Whittier, former executive director of Michigan Medical Service, who is the present executive director of the National Society for Chippled Children and Adults, reports that last year nearly a quarter million handicapped persons received help from the Easter Seal societies.

The annual Easter Seal campaign is the Society's main source of income. Funds contributed at that time will support some 2,000 facilities and other Easter Seal Society programs.

PLAN PHYSICIAN-HOSPITAL CONFERENCE FOR MAY

MSMS will cooperate with the Michigan Hospital Association and several other organizations in the sponsorship of a spring meeting to discuss physician-hospital relations. The meeting for hospital administrators, hospital trustees, and physicians, is the outgrowth of a similar meeting sponsored last year by MHA on relations between medical staffs and trustees.

Leo W. Walker, M.D., Lansing, represented MSMS at the first planning meeting. The program is tentatively May 8-11 at Boyne Mountain.

BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

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One block south of I-96 at Kensington Rd. Exit
four miles east of U. S. 23
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ACademy 7-1211

GURDJIAN AMONG SPEAKERS FOR WSU CENTENNIAL SEMINAR ON DIMENSIONS

The Wayne State University Centennial symposium, May 6-10, will focus on "Technology and the City: Human and Social Dimensions." This symposium will explore the implications for the individual and groups of the city considered as a concentration of the human functions of communication, transport, and energy.

One of the speakers will be Elisha S. Gurdjian, M.D., chairman, department of neurosurgery, WSU School of Medicine, professor of neurosurgery in engineering mechanics, and director of the WSU biomechanics research center.

Among the other speakers will be William O. Baker, Ph.D., vice-president for research, Bell Telephone Laboratories, J. E. Goldman, Ph.D., director, scientific research laboratories, Ford Motor Company; and Professor B. F. Skinner from Harvard University.

The final symposium in the Centennial series is "The City of Man: The University and Urban Culture," May 15-17.

A group of 100 of Detroit's most distinguished civic leaders, with Mayor Jerome P. Cavanagh and Governor Romney as Honorary Chairmen, are planning a civic banquet for June 13, 1968, as a salute from the City of Detroit to Wayne State, timed to coincide with the 100th Anniversary date of the issuance of the charter to the first of Wayne's colleges, the School of Medicine.

WANT TO TOUR AMA?

Planning to be in Chicago in the forseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 North Dearborn just north of the Loop, anytime during office hours—8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

Booklet by Michigan Board of Education Reports MSMS Aids

The State Board of Education has published a new booklet which includes MSMS as a resource organization for schools who want help in setting up educational programs relating to health.

Called "Resource Guide for Health, Physical Education, Recreation and Outdoor Education," the booklet also lists 22 other governmental, professional, and voluntary organizations which stand ready to help schools develop programs relating to accident prevention, smoking, use of alcoholic beverages, drug abuse, growth and development, family life and sex education, physical fitness, and many others.

The booklet was prepared by the State Educational Planning Council for School Health Education, Physical Education, Outdoor Education and Recreation. Members of the Council include several MSMS physicians who represent various organizations: Eleanor Skufis, M.D., Adrian, from MSMS; Fred Moench, M.D., Midland, from the Michigan Health Officers Association; William H. Kelly, M.D., Lansing, Michigan Department of Mental Health; and Marshall J. Blondy, M.D., Detroit, Wayne County Medical Society.

On the page about MSMS, the state booklet describes the following MSMS objectives: "To encourage and assist educational institutions to carry out general and specific health educational programs and activities; To provide authentic, accurate information to students, teachers, and parents."

The booklet reports that the following committees are concerned about various aspects of child and school health: Child Welfare, Diabetes, Maternal Health, Family Life Education, Mental Health, Public Health, Public Relations, Rural Medical Services, Venereal Disease Control, Alcoholism and Drug Addiction, Disaster Medical Care, Eye Care, Medical Aspects of Organized Athletics, and Rehabilitation.

FUTURE AMA CONVENTIONS:

Sites and dates for future conventions will be:

ANNUAL

1968 San Francisco, June 16-20
1969 New York, July 13-17
1970 Chicago, June 21-25
1971 Atlantic City, June 20-24
1972 San Francisco, June 18-22
1973 New York, July 15-19
1974 Chicago, June 16-20

CLINICAL

1968 Miami Beach, December 1-4
1969 Denver, Nov. 30-Dec. 3
1970 Boston, Nov. 29-Dec. 2

ACTIVITIES, PROJECTS

10,000 Medi-Labels Recently Distributed

Since December 1, over 10,000 Medi-Labels have been mailed to private physicians and medical directors of automobile plants.

MSMS now is developing plans with some lay groups to authorize their distribution, but want it clearly understood that all information on the Medi-Label must be affixed to the sticker by the physician.

ABELL, WALKER, KNIGHTS LEAD STATE PATHOLOGISTS

President of the Michigan Society for Pathologists for the coming year is Murray Abell, M.D., professor of pathology, University of Michigan School of Medicine. President-elect is Leo Walker, M.D., director of laboratories, St. Lawrence Hospital, Lansing. Edwin Knights, Jr., M.D., Lansing, was re-elected secretary-treasurer.

At the recent annual meeting, the eighth annual Carl V. Weller Lecture was delivered by Frank Hartman, M.D., former director of the department of pathology at Henry Ford Hospital and currently medical research advisor, Office of Surgeon General in Washington, D. C. Doctor Hartman's talk dealt with the topic "Informed Consent in Human Experimentation."

The annual meeting also featured a seminar on "Tumors of the Breast" conducted by Harold Oberman, M.D., associate professor of pathology, University of Michigan School of Medicine.

Sees Need to Graduate Many More Physicians

American universities should be graduating at least 1,200 more doctors each year than are actually being produced, Dean William N. Hubbard Jr., M.D. of the University of Michigan Medical School, has often declared.

"It is highly probable that the figure might well be closer to 2,000," he says. "Throughout the United States and the halls of Congress there is a notable lack of the boldness and determination needed to increase the number of physicians in our country."

Urges Continuing Use Of Iodized Salt in State

"If this workshop were held 45 years ago, the discussions presented would have, undoubtedly, centered around the overwhelming incidence of endemic goiter in the State of Michigan, when nearly 40% of all school children examined were found to have enlargement of their thyroid glands due to iodine starvation," said Harry A. Towsley, M.D., Chairman of the Department of Postgraduate Medicine at the University of Michigan Medical Center, in a talk on "Goiter in Michigan" at the recent Seventh Annual Thyroid Workshop, sponsored by the Wayne State University School of Medicine and Detroit General Hospital, in Detroit.

Doctor Towsley outlined the fight against goiter by recalling the work of a committee in 1922 which had been appointed by the Pediatric Section of MSMS to study the problem.

Studies indicated that Michigan soil and water contained only slight quantities of iodine. After discussion, the committee concluded that addition of iodine to table salt would be the most effective solution to the problem, even though this method had been used and abandoned in Europe.

MSMS, the Salt Distributors Association, the Michigan Health Department, and William J. Hale, a well-known Midland chemist, worked together to develop a salt containing a minimum of "0.01% and maximum of 0.02%" iodine, which could be used in all table and cooking salt. In the spring of 1924, iodized salt was on the market. Then followed an educational effort on the part of the committee, the press, and nearly 200 MSMS members "which probably has been unequalled in intensity or success by any organized medical group," said Doctor Towsley.

Ten years later, a survey showed a marked reduction of goiter in Michigan school children.

There has been a continuing decline, but at the same time "There is very substantial evidence that the need for continuing public education in the use of iodine-containing salt is essential," Doctor Towsley continued.

"The Iodized Salt Committee of the Michigan State Medical Society has, on frequent occasions, promoted the establishment of legislation comparable to that in Canada and some European countries, requiring iodization of all salt for human and animal consumption," Doctor Towsley concluded. "Such legislation has not been forthcoming and until it does, it is the responsibility of every physician in Michigan to insist that his patients continue to use iodized salt for the prevention of endemic goiter."

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

RPIDINE
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Enduron: (methyclothiazide) A basic building block for mild hypertensives

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Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient' sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persits for a full 24 hour With Enduron you can prescribe convenient once-a-day dosag without skimping your patients on day-long thiazide effectivenes

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample i most cases.

Once a day, every day

ENDURON

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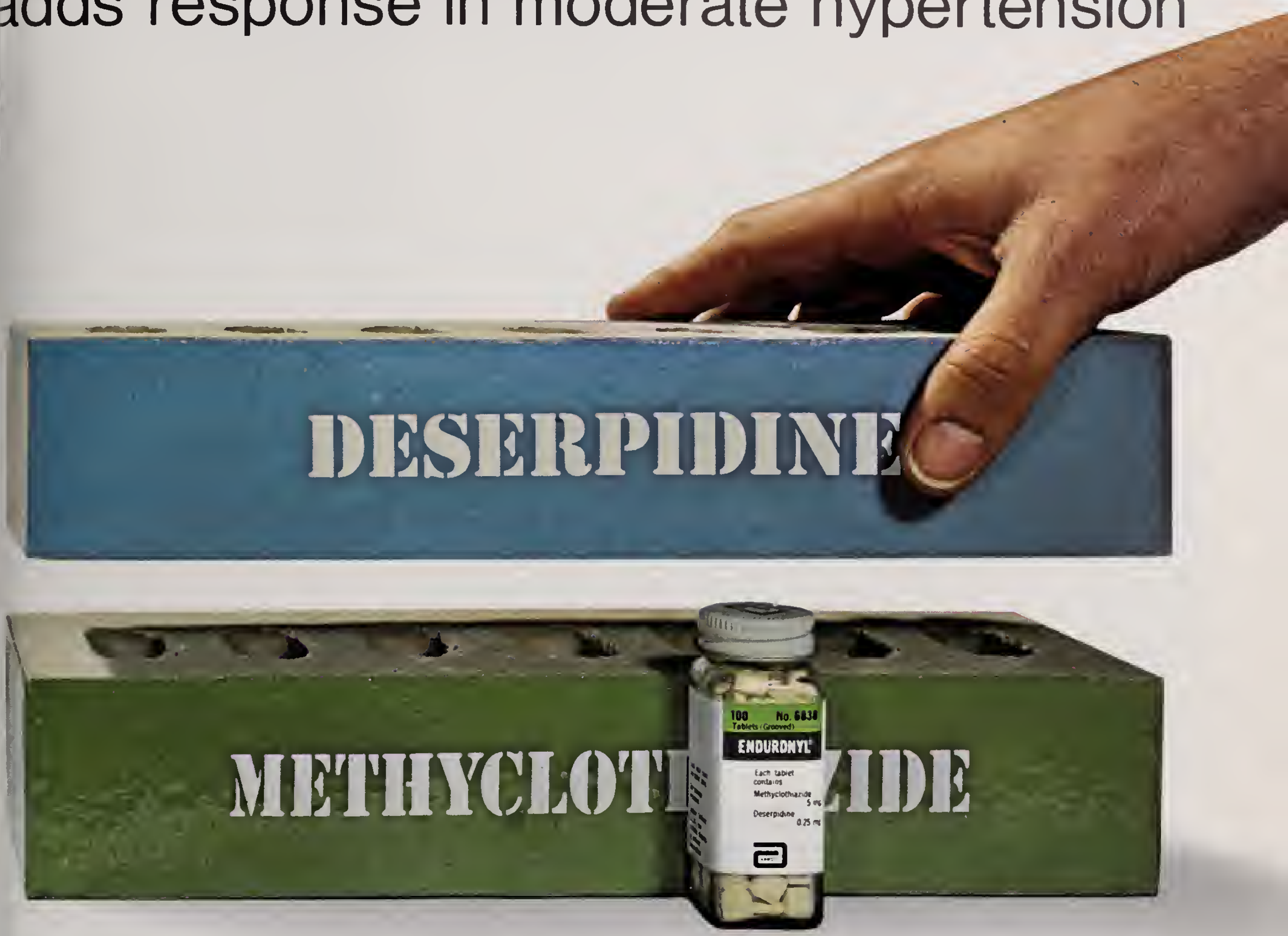
Enduronyl: Its deserpidine component adds response in moderate hypertension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Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
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Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

ETHYCLOTHIAZIDE 5 mg. with
ESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE

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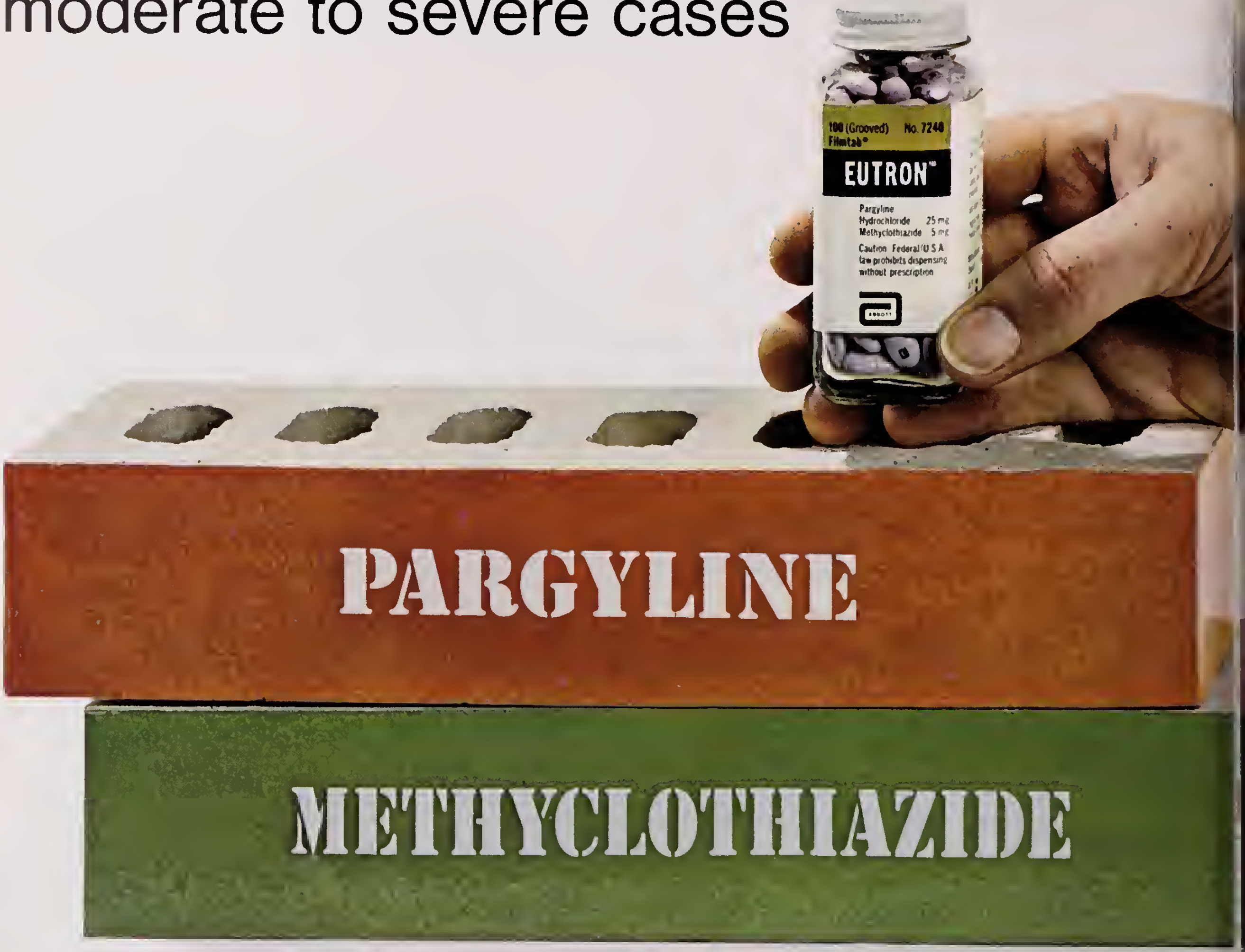
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Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

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PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

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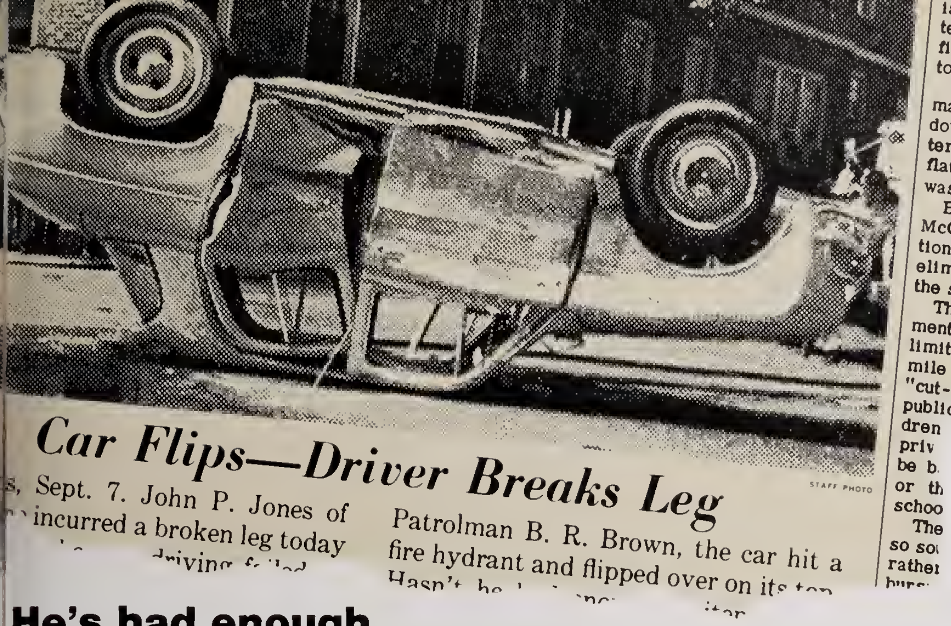

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Car Flips—Driver Breaks Leg

STAFF PHOTO

s, Sept. 7. John P. Jones of
incurred a broken leg today

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (1/4 gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), 1/2 gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

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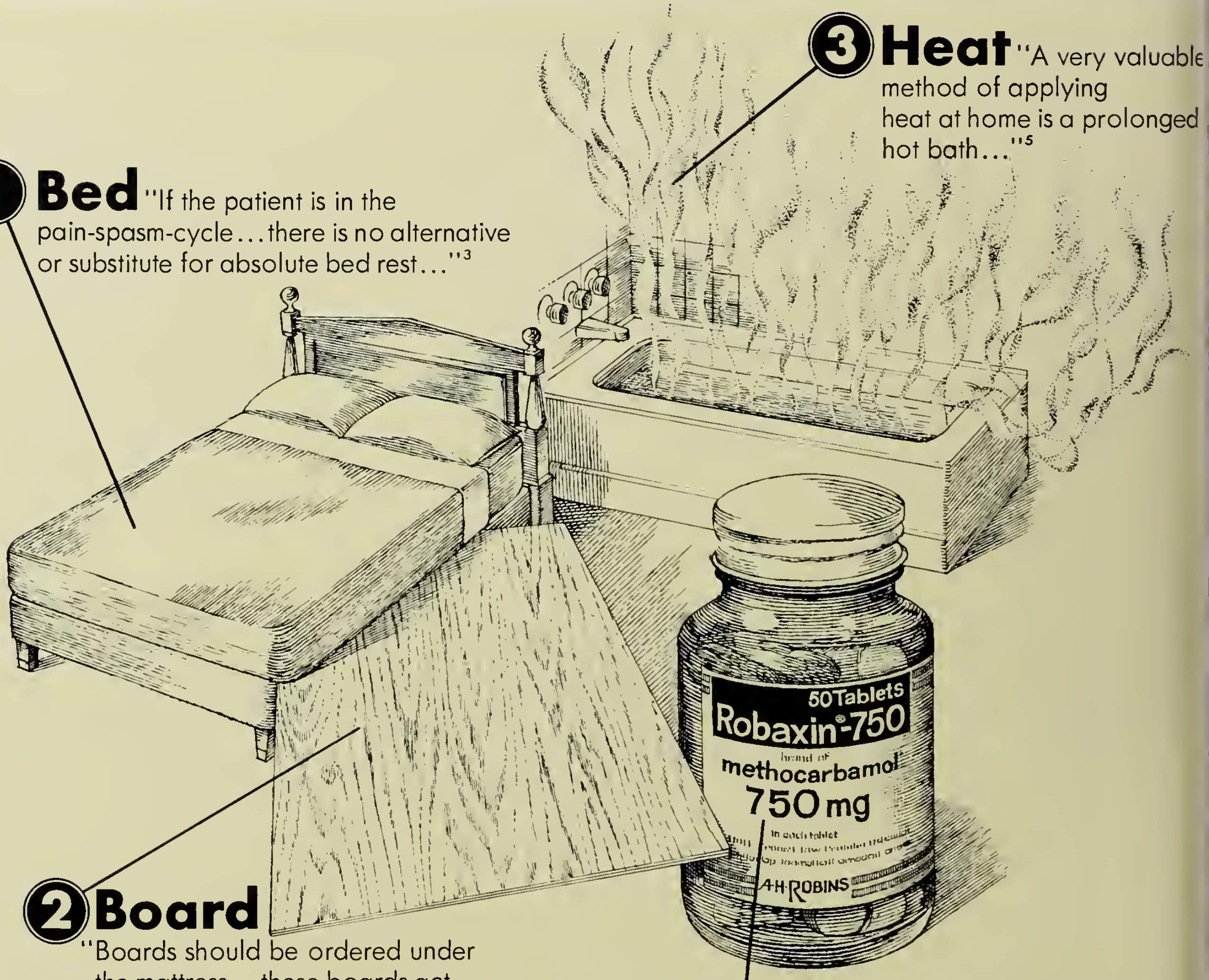
LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



③ Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

① Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

② Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

④ Robaxin®-750

(methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.) **References:** (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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U-M CLINICAL RESEARCH UNIT GETS NEW GRANT

To continue its work of caring for some 500 patients each year, the U.S. Public Health Service has awarded $751,639 to the Clinical Research Unit at the University of Michigan Medical Center.

Medical school faculty members have conducted nearly 100 research projects since the 20-bed unit opened in 1962, thereby not only giving care to hundreds of patients, but also adding to medical knowledge.

During 1967, the unit cared for 517 patients and the staff was involved in 40 research projects.

SEARLE STEPS UP EDUCATIONAL SERVICES

Samuel N. Turiel has begun duties as Director of the newly-created Department of Professional Education at G. D. Searle & Company, Chicago.

The department will develop a nucleus of physicians and scientists to serve as both an educational advisory board, as well as available faculty for symposia and continuing medical education programs in a wide range of specified diagnostic and therapeutic areas of medicine. These special programs and symposia will be made available for use by directors of medical education at hospitals in addition to interested medical societies.

Meet the Members of The MSMS Council

Members of the MSMS Council and the MSMS officers took time out from the December meeting to pose for their annual official photograph. Shown on the steps of the MSMS Headquarters are, left to right:

Front row — Treasurer John R. Ylvisaker, M.D., Pontiac; Secretary Kenneth H. Johnson, M.D., Lansing; Council Vice-Chairman Ross V. Taylor, M.D., Jackson; President-Elect James J. Lightbody, M.D., Detroit; Council Chairman Robert J. Mason, M.D., Birmingham; President Bradley M. Harris, M.D., Ypsilanti; Past President Luther R. Leader, M.D., Royal Oak; Councilor Robert K. Whiteley, M.D., Grosse Pointe; Past President C. Allen Payne, M.D., Grand Rapids;

Second row — Councilor Ralph R. Cooper, M.D., Detroit; Vice-Speaker Vernon V. Bass, M.D., Saginaw; Councilor Don W. McLean, M.D., Detroit; Councilor John J. Coury, M.D., Port Huron; Councilor Robert V. Daugharty, M.D., Cadillac; Councilor Harold H. Hiscock, M.D., Flint; Councilor Harold F. Falls, M.D., Ann Arbor; Councilor Brooker L. Masters, M.D., Fremont;

Back row — Councilor Edward H. Rodda, M.D., Bay City; Councilor Sidney Adler, M.D., Detroit; Councilor J. Robert Franck, Jr., Wakefield; Councilor John R. Pedden, M.D., Grand Rapids; Councilor A. Carl Stander, M.D., Saginaw; Councilor Harvey C. Hansen, M.D., Battle Creek; Speaker James B. Blodgett, M.D., Detroit; Councilor Don Marshall, M.D., Kalamazoo.

Doctor Leader is chairman of the MSMS delegation to the AMA. Not included in the photo are Councilor Milton R. Weed, M.D., Detroit, and Councilor Eugene R. Elzinga, M.D., Marquette.

Florida Professor Named Chairman of New MSU Human Development Department

The MSU College of Human Medicine has established a department of human development with a prominent Florida pediatrician as its chairman. The appointment of William B. Weil, M.D., currently A. I. duPont professor for handicapped children at the University of Florida, is effective Aug. 1, 1968.

The new department will be responsible for the first year of the human biology sequence.

Secretary-treasurer of the Society for Pediatric Research, Doctor Weil was appointed at Florida as an associate professor of pediatrics in 1963 and to his present position in 1965.

Previous appointments held by Dr. Weil include that of assistant professor of pediatrics at Western Reserve University; associate pediatrician with University Hospitals of Cleveland, special postdoctoral fellow at Cambridge University, England, and public health postdoctoral fellow and Harvard research fellow at Harvard University

He received his M.D. in 1948 at the University of Minnesota.

MOON TO SUPERVISE BALDWIN OEO PROJECT

William W. Moon, M.D., of Cadillac, has recently been named medical director of a comprehensive neighborhood health services program for low-income rural residents located in Lake county, and portions of Newaygo, Mason, and Manistee counties.

Funded by a $942,713 grant from the federal Office of Economic Opportunity, the program combines the effects of the State Department of Public Health, Michigan State University's College of Human Medicine, and Five-Cap, Inc., the local OEO organization.

Doctor Moon has practiced in Cadillac as a general practitioner since 1951.

U-M GRAD DIRECTS NIMH

James D. Isbister has been appointed executive officer of the National Institute of Mental Health, a bureau of the U.S. Public Health Service. Mr. Isbister received his B.A. from the University of Michigan in 1958, and his M.A. from George Washington University in 1966. He has received the Regents Alumni Honor Award from the University of Michigan.

Prior to joining NIMH, Mr. Isbister was Executive Officer of the National Library of Medicine from 1965 until his new appointment.

MOYER, NINE OTHERS CITED BY MAGAZINE

Carl A. Moyer, M.D., Houghton, recently was named by *Modern Medicine* among 10 recipients of its 1968 Awards for Distinguished Achievement. Doctor Moyer, professor of biological sciences and director of research at Michigan Technological University, was cited for his research in burn therapy leading to more effective management of extensive burns.

One of Doctor Moyer's current projects is a program wherein the six counties of the Michigan Upper Peninsula and Michigan State University have joined forces to provide comprehensive health care to the area and to train medical and other health profession students. He is director of the heart-cancer-stroke project of the plan and has been named professor of medicine, on a voluntary basis, by MSU.

JACKSON AUXILIARY HOLDS SEMINAR ON CAREERS

School principals and counselors in Jackson County recently learned more about job opportunities in the medical field, through the efforts of the Woman's Auxiliary to the Jackson County Medical Society.

A seminar at Foote Hospital featured a panel of representatives from various health careers. Richard K. Waeschle, M.D., represented medicine on the panel, which was moderated by the health counselor at the community college.

"Horizons Unlimited," a movie produced by the AMA was shown, and, following dinner, talks were given by Robert E. Kinsinger, educational director of the W. K. Kellogg Foundation, and John A. Doherty, executive director of the Michigan Health Council.

MD Placement Notice

—Looking for a smaller town that needs and wants a physician?

—Do you need an associate or assistant in your practice?

—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)
(No charge for this service)

ANNOUNCE PROMOTIONS AT PARKE-DAVIS

The Board of Directors of Parke, Davis & Company has made a broad realignment of the company's top operating management.

Austin Smith, M.D., Chairman of the Board and Chief Executive Officer, has been named to the office of President, formerly held by Harold W. Burrows, who retired December 31.

C. D. Smith, Executive Vice President, becomes a member of the Board's Executive Committee, and will act as its secretary.

William G. Meier, who has been Vice President, Production and Engineering, was appointed Administrative Vice President.

L. M. Lueck, formerly Director of Quality Control, has been elevated to Vice President for Quality Control and Government Relations.

Joseph F. Sadusk, Jr., M.D., who has been Vice President for Medical Affairs, was named Vice President for Medical and Scientific Affairs.

Carl Johnson was appointed Vice President for Corporate and Community Relations. He has been Vice President, Advertising and Public Relations.

L. A. Sweet, formerly Vice President, Research, has been named Vice President for Research Development and Application, a newly-created office.

"The new alignment places continued strong emphasis on our research, quality control and medical affairs, and broadens the administrative responsibilities for the renewed growth period ahead," the Board said.

Doctor Smith, 55, joined Parke-Davis in December, 1965, as a member of the firm's Board of Directors, and on January 1, 1966, became Vice Chairman of the Board. A year ago, he was elected Chairman. Between 1959 and when he joined Parke-Davis, Dr. Smith served as President and Chief Executive Officer of the Pharmaceutical Manufacturers Association, and before that was editor of the American Medical Association Journal.

Doctor Sadusk, 58, joined Parke-Davis last April 1 from the Johns Hopkins University School of Medicine where he had been professor of Medicine and associate dean. He has held numerous faculty positions at medical schools around the country and also served as medical director for the Food and Drug Administration.

CORSSEN TO ALABAMA

Guenter Corssen, M.D., University of Michigan professor of anesthesiology, will leave the U-M faculty in April to become chairman of the department of anesthesiology at the University of Alabama Medical Center, Birmingham.

VISIT A 19th CENTURY ONE MAN CLINIC

and the panorama of American History at Henry Ford Museum and Greenfield Village. See the office of Dr. Alonson Howard . . physician, surgeon, dentist, chemist, apothecary . . . the classical example of the country doctor. Plan a family adventure today. Stay at the Dearborn Inn, only 700 yards from the museum and its unmatched mechanical and fine arts collection. May we send our brochure.

180 thoroughly modern guest rooms in the Inn, Colonial Homes, Motor House from $13 single, $18 double. Two restaurants, cocktail lounge.

The Dearborn Inn

OAKWOOD BLVD. DEARBORN, MICHIGAN 48123 (Area 313) 271-2700

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient card
arrhythmias have occurred in hy
thyroid patients and in patients
ceiving thyroid medication wher
Tofrānil was added to the regim
Imipramine may block the pharr
cologic activity of guanethidine
other related adrenergic neuron
blocking agents.
The drug is not recommended a
present time in patients under 1
of age.
Adverse Reactions: Dryness of t
mouth, tachycardia, constipatio
turbances of accommodation, s
ing, dizziness, weight gain, urin
frequency or retention, nausea a
vomiting, peripheral neuritis, mi
parkinson-like syndrome, tremo
rare cases of falling in elderly p
tients, confusional states (with s
symptoms as hallucinations and
orientation), activation of psych
schizophrenics and agitation (ir

When a milestone in life is marred by depression...

Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride
Geigy

pomanic and manic episodes)
may require dosage reduction
r addition of a tranquilizer or
rary discontinuation of the drug,
tiform seizures, orthostatic
ension and substantial blood
ure fall in hypertensive patients,
ra, transient jaundice, bone mar-
epression including agranulocy-
sensitization and skin rash
ing photosensitization, eosino-
and mild withdrawal symptoms
dden discontinuation after pro-
d treatment with high doses.
ional hormonal effects (im-
ce, decreased libido, and estro-
effects) may be observed.
ne-like effects may be more
unced (e.g. paralytic ileus) in
ptible patients and in those
anticholinergic agents (includ-
tiparkinsonism drugs).
tient Adult Dosage: Initially,
. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

The helicopter ambulance brings in a patient to the University Hospital. Ground attendants (foreground) have come to meet the helicopter with stretchers and blankets.

HELICOPTER AMBULANCE SERVICE STARTED

BY PETER HOHEISEL
OF THE MSMS STAFF

One recent day, luncheon patrons of the Wyandotte Yacht Club on the Detroit river were surprised when a small helicopter whirled out of the blue sky and gently touched down on the snow covered lawn between the Yacht Club and the river.

The performance was designed for C. Mark Vasu, M.D., chairman of the emergency medical services committee of Kent County Medical Society, and several Grand Rapids city officials who were conferring with managers of Superior Ambulance Service in Wyandotte about ambulance service as part of total emergency care.

The helicopter, a Bell Ranger 47-J, has been in use by the company since the middle of December; it is the first time a private company has relied upon a helicopter as an ambulance vehicle.

Superior owns one helicopter. Another is available on a contract basis from a Detroit area aviation organization.

"The land ambulance is still primary, but we feel helicopters can perform an invaluable back up service, especially for certain cases," explains Walter Gutowski, president of Superior Ambulance Service.

"For example, in our first case we transferred a severely burned patient from Wayne County General Hospital to the Intensive Burn Care Unit at Ann Arbor in 16 minutes," Mr. Gutowski continued.

"A land run at a similar time of day would have taken about 45 minutes. The man had a progressive, chemical burn and every minute we could save in getting him to Ann Arbor was vitally important," Mr. Gutowski said.

With its home base at National Airport in Westland, the Ranger is now ready to provide emergency transportation within a 100-mile-radius of Ann Arbor. University of Michigan has plans to blacktop, fence, and light a landing pad which is only 100 yards from the emergency room entrance.

Cases most apt to benefit from the service are head injuries, severe burns, and spinal injuries.

The Ranger can carry two litters inside the cab. It has two kits — a standard doctor's bag and a first aid kit. Cruising at 90 mph, the helicopter can carry two patients and a pilot or a patient, attendant, and pilot.

"With its night-flying equipment and our capability of flying in almost any weather, with the exception of icy conditions, our service provides dependable emergency transportation," explains Philip Nelson, an operational manager at Superior Ambulance.

"The appeal for doctors," Mr. Nelson said, "is that it reduces liability. The physician who first sees an emergency patient is responsible, in case of transfer, until that patient is in another doctor's care."

"The physician who must transfer a patient is concerned with speed, smooth transferal, and a trained attendant to look after the person," Mr. Nelson continued. "The helicopter can cut the time from emergency room to emergency room by about 70%. The patient is in a controlled environment and he has a smooth ride."

"Good emergency medical care," Doctor Vasu continued, "involves first aid and rescue, communication, transportation, and emergency facilities. Emergency facilities will include all the necessary equipment plus training for the people who are in first contact with the injured person."

Totally efficient emergency medical care throughout the state is at present a dream. In fact, with funeral directors going out of the ambulance business, gaps are showing up.

The helicopter will not answer the problem of decline in land ambulance service because it cannot do the job of a land ambulance. It promises, nevertheless, to be a valuable tool in meeting some of the problems in the field of emergency medical care.

NINE MICHIGAN MEN JOIN AMA COMMITTEES

Nine Michigan men are among those named to membership on AMA councils and committees. The appointments, which were approved by the AMA Board of Trustees, are for a term of one year with a maximum tenure of 10 consecutive terms.

The AMA reports that Bertram D. Dinman, M.D., Ann Arbor, was appointed to the Committee on Ocupational Toxicology. Reappointed to committees were: Roger G. Hansen Ph.D., East Lansing, Council on Foods and Nutrition; Herbert A. Raskin, M.D., Detroit, and Maurice H. Seevers, M.D., Ann Arbor, Committee on Alcoholism and Drug Dependence; Starling D. Steiner, M.D., Detroit, Council on Occupational Health; Richard C. Schneider, M.D., Ann Arbor, Committee on Medical Aspects of Sports; Alexander H. Hirschfeld, M.D., Detroit, Joint Committee on Mental Health in Industry. Donald J. Birmingham, M.D., Detroit, was reappointed to the Committee on Rating of Mental and Physical Impairment and reappointed chairman of the Subcommittee on Skin; John W. Rebuck, M.D., Detroit was reappointed to the Subcommittee on Hematopoietic and Lymphatic Systems.

The AMA reports that William D. Robinson, M.D., Ann Arbor, has retired from the Council on Foods and Nutrition; and Charles G. Child, III, M.D., Ann Arbor, from the Committee on Nursing.

In addition to the above Michigan men who have been appointed by the AMA Board of Trustees, George W. Slagle, M.D., of Battle Creek, serves as chairman of the AMA Council on Medical Service. He was elected to the Council by the AMA House of Delegates.

NEERKIN GIVEN AWARD FOR SAVING BOY'S LIFE

A. J. Neerken, M.D., Kalamazoo, has been honored by the Carnegie Hero Fund Commission of Pittsburgh, Pa., for saving a 16-year-old boy's life.

On December 26, 1965, Doctor Neerken saw two boys fall through thin ice on Woods Lake. One of the boys drowned but Doctor Neerken, himself going through the inch-thick ice, was able to keep Richard Fish afloat until Kalamazoo firemen rescued them both.

The belated award is a bronze medal.

Auxiliary Members Help In Legislative Arena

BY MRS. W. G. GAMBLE, JR., BAY CITY
PRESIDENT, WOMAN'S AUXILIARY

The Auxiliary is organized to assist MSMS in its legislative activities — we are at your service, awaiting your call to action! Auxiliary members are available to contact legislators about issues vital to the medical profession.

To further its members' knowledge about legislation, the Auxiliary will hold, for the first time, a "Legislative Day." Scheduled for March 12 in Lansing, state officers and presidents, presidents-elect, and legislative chairmen from all county medical auxiliaries will be invited to this special event.

On the day's agenda will be briefings about current topics such as the impending chiropractic bill (Senate Bill 227), Michigan's Basic Science Law (Senate Bill 229), etc., a film, "The People of Michigan Enact" which illustrates the law-making procedure in Michigan, and, in the afternoon, a personal meeting of each Auxiliary member with her legislator.

MEMBERS OF THE Auxiliary also attended the recent Detroit meeting on "The Doctors, the Law, and the Courts," and, to keep abreast of current legislative matters, county legislative chairmen receive the *MSMS Medigram* and the *AMA Legislative Roundup*. Furthermore, Mrs. Donald S. Bolstad, Dearborn, State Auxiliary Legislative Chairman, is an exofficio member of the MSMS Legal Affairs Committee, and she reports MSMS legislative activities to Auxiliary members and enlists their aid.

Legislation is of vital concern to the profession of medicine — that no one will debate. However, doctors, being as busy as they are with professional duties, seldom have sufficient time to devote to "outside" activities such as legislation.

HOWEVER, THE AUXILIARY is available and ready to help. When the need arises to voice an opinion on a medical issue, Auxiliary members can contact their elected representatives by letter, telephone, or personal meeting.

Let us help you help others through legislation!

Group Elects Tryloff

Warren Tryloff, MSMS Associate Director, was recently re-elected treasurer of the Professional Convention Management Association. The election took place at the Joint Conference of Medical Conventions, a meeting of medical society convention managers and pharmaceutical convention managers for the discussion of mutual problems and interests.

Sustained circulatory, respirator
and cerebral stimulation for th

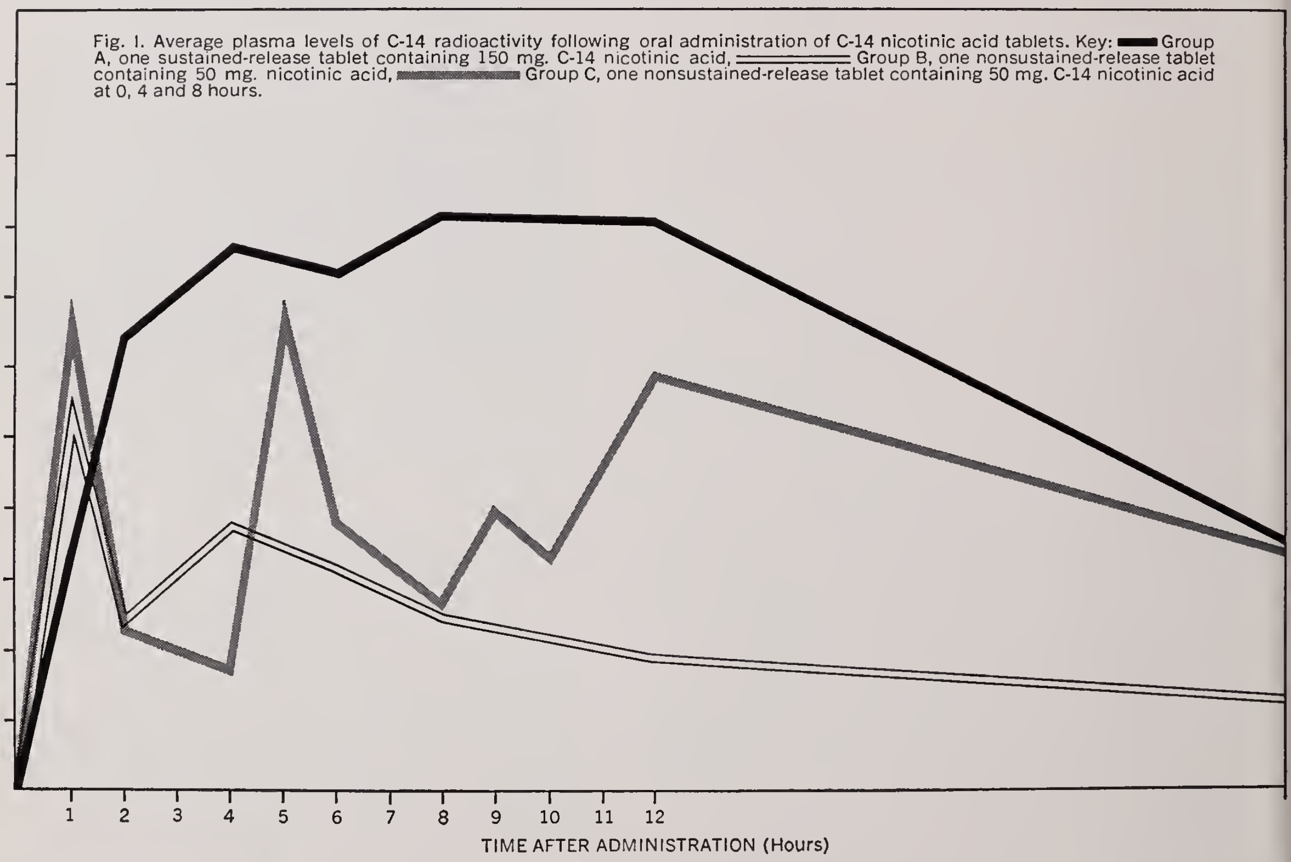
Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

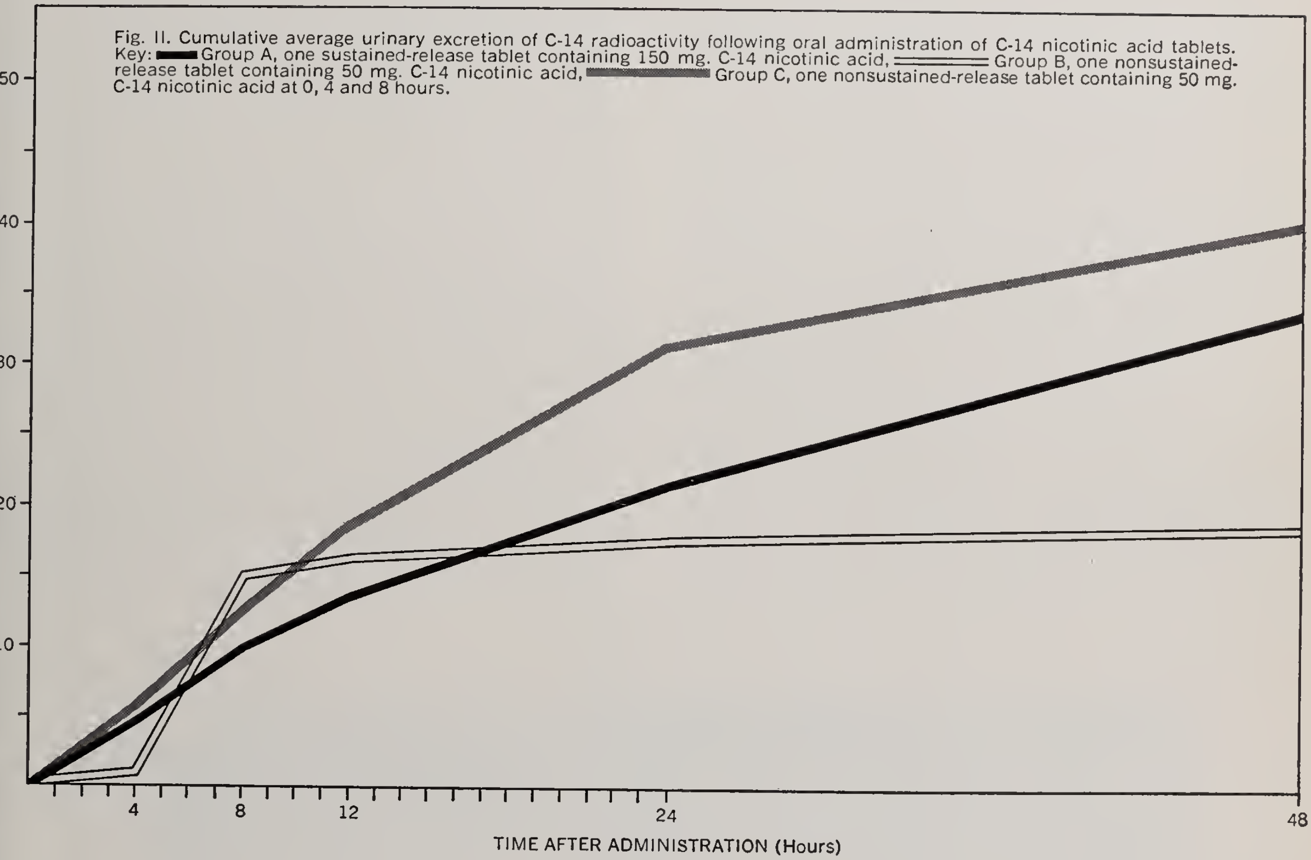
Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindica-ons.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

Michigan Influenza Outbreak Described

BY MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The epidemic of influenza A_2, which began in Michigan in October 1967 was virtually over by mid-January, except for a few sporadic cases. Every county of the state experienced an outbreak, although the severity of illness and the proportion of the populace that was ill varied quite a bit from place to place at the end of January.

Serologic confirmation of the outbreak of influenza A_2 by compliment fixation was made on specimens from 13 counties: Kalamazoo, Ingham, Calhoun, Washtenaw, Wayne, Kent, Marquette, Saginaw, Macomb, Barry, Genesee, St. Clair, and St. Joseph. More specimens from other counties are still being examined.

Typical outbreaks in any given place began in the high schools with a few cases of febrile respiratory illness followed about one week later by a sudden outbreak of typical influenza with absenteeism usually reaching 25-30% in the first days of the outbreak. Within one week the grade school children and adults would become ill, and by the end of the second week, only sporadic cases would still be occurring. The outbreak lasted longer in the larger cities.

School absenteeism usually was 25-30% on the peak days of the epidemic, although Traverse City reported 50% and Hesperia, in Newaygo county, reported 70%. Industrial absenteeism was slight.

Influenza first appeared at Western Michigan University in Kalamazoo in the 43rd week (October 22-28). The school children in Kalamazoo were also affected, and a week later, influenza appeared in Battle Creek in Calhoun County. Influenza next appeared in Lansing in the 46th week (November 12-18), just before the Thanksgiving vacation, when all the Michigan State University students went home for vacation. Following this, the disease spread much more rapidly in all directions, especially, to the north and east to the major population centers of Saginaw, Genesee, Wayne, Oakland, and Macomb counties. During the 50th week alone (December 10-16), the northern half of the Lower Peninsula experienced its epidemic, as well as much of the Upper Peninsula. During the remaining two weeks the epidemic moved westward across the Upper Peninsula.

The apparent jump of the illness from the Kalamazoo-Battle Creek areas to Lansing, and the more rapid dispersal from Lansing around Thanksgiving was possibly due to movements of college students on vacation and high school basketball games.

---

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IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

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Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
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Write for literature and samples:
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also available with ESTROGEN
Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Speech at MSMS Meeting Now in National Journal

The speech of C. Howard Ross, M.D., Ann Arbor, before the MSMS Conference on Medical News Reporting has been printed in *Medical Times*.

The address, entitled "The Evangelism of Communications," was the after-dinner speech at the 1965 Conference at MSU and the MSMS headquarters. Doctor Ross, president of Michigan Medical Writers Association, recalled some quotations from great medical and world figures. The article appeared in Vol. 95, No. 9 of *Medical Times*.

OFFER SCHOLARSHIPS TO ALCOHOL INSTITUTES

The Michigan Department of Public Health Alcoholism Program will offer 50 scholarships to participants at the Midwest Institute of Alcohol Studies and the Rutgers Summer School of Alcohol Studies.

The scholarships, limited to Michigan residents, provide tuition, room and board for concerned professional and lay people. Scholarships have also been given to Alcoholics Anonymous members in an effort to strengthen the relationship between A.A. and the helping professions.

Midwest Institute will be held at Northwestern University, Evanston, Illinois, June 16 through 21, 1968. The Rutgers Summer School will be held from June 30 through July 19, 1968, at Rutgers

Applications for scholarships may be secured from the Michigan State Department of Public Health Alcoholism Program, 3500 North Logan Street, Lansing, Michigan 48914.

Receive U.S. Grants

Two Wayne State University Medical School professors are recipients of recent U.S. Public Health Service grants. Gianfranco Dal Santo, M.D., Franklin, professor and chairman of anesthesiology in Wayne State's School of Medicine, was awarded $24,291 for a study of the dynamics of anesthetic agents. For continuation of research entitled "Biochemical Mechanisms of Tissue Repair," $22,657 went to Richard J. Bing, M.D., Birmingham, M.D., professor and chairman of the department of internal medicine.

DID YOU KNOW . . .

. . . that the current worth of chemicals in the human body has recently been quoted at $800 by scientific researchers? The value, once quoted at 98¢ has gone up due to the demand for enzymes and nucleic acids.

Easy on the Budget...
Easy on the Mother

Tablets & Elixir
For Iron Deficiency Anemia

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Fergon®
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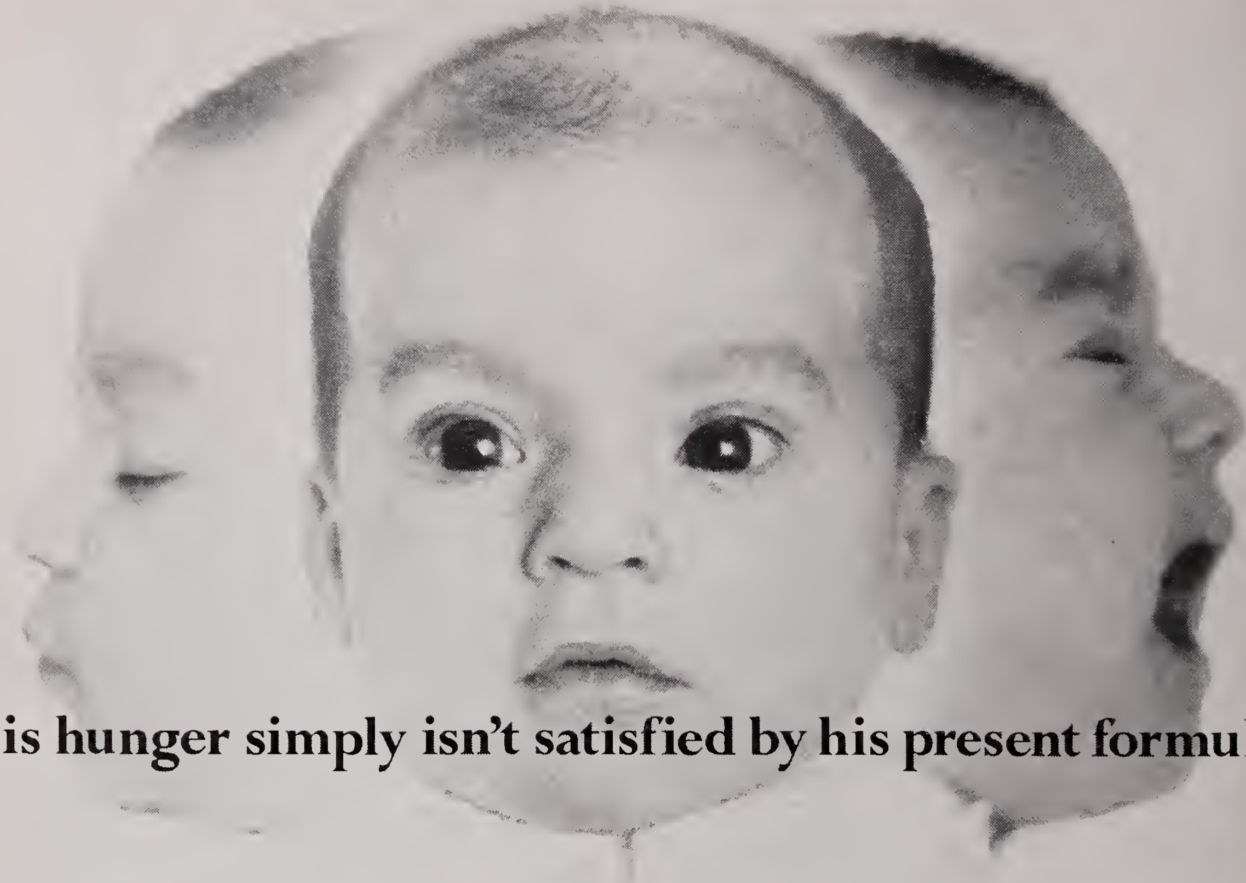


If his hunger simply isn't satisfied by his present formula..

the problem could be essential fatty acid imbalance

Excessive appetite, inordinate crying, poor weight gain and skin rashes can be caused by an infant formula that does not have fatty acid balance.[1-5] Linoleic acid is a required nutrient which is converted, in part, to metabolically-active arachidonic acid. Preliminary studies have shown that linolenic acid, if present in sufficient quantity, can adversely affect thi conversion. Optimil has only tra amounts of linolenic acid.

Fat analyses of Optimil and two leading modified-milk formulas*

Fatty acids	Optimil % of fat	Prod. #2 % of fat	Prod. #3 % of fat
Saturated	**40.4**	**44.2**	**39.0**
Caprylic	3.3	1.6	2.2
Capric	2.2	1.1	1.5
Lauric	16.0	10.1	11.7
Myristic	6.3	5.1	5.5
Palmitic	10.2	16.2	14.0
Stearic	2.3	9.0	4.5
Unsaturated	**59.6**	**55.8**	**61.0**
Oleic	40.7	33.0	24.7
Linoleic	18.9	19.5	34.6
Linolenic	trace	2.3	1.7

* Mean of three lots tested

ptimil, an optimum-nutrition infant formula, helps reduce problem

feeding

w Optimil from Carnation ntains more than enough linoleic d and only a trace of linolenic. us Optimil-fed infants maintain equate tissue levels of chidonic acid. This is reflected the high caloric efficiency Optimil, and helps to satisfy nger and promote efficient ight gain and a clear complexion nakes an infant contented.[6-8]

ecommend Optimil

r optimum contentment, imum digestibility and optimum wth, recommend Optimil, the imum-nutrition infant formula. mes in the new full 16-fluid nce can for maximum nvenience in formula preparation. ailable only at drug stores.

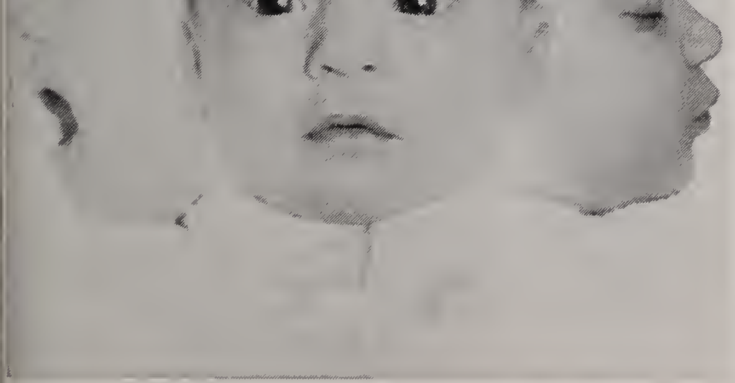
in digestibility

Of all the fatty acids commonly found in infant formulas, stearic acid is the least digestible.[9] Optimil contains a comparatively low level of stearic acid and a relatively high level of oleic acid, which has been shown to aid in the absorption of stearic acid. Optimil also has a high ratio of unsaturated fat to saturated fat which further enhances the formula's digestibility.

1. Hansen, A. E., et al: Pediatrics 31:171, 1963. 2. Holman, R. T.: Fed Proc. 23:1062, 1964. 3. Holman, R. T., et al.: Amer. J. Clin. Nutrition 14:70, 1964. 4. Hepner, R., et al.: Pediatrics 33:94, 1964. 5. Pikaar, N.A., and Fernandes, J.: Amer. J. Clin. Nutrition 19:194, 1966. 6. Hepner, R.: Current Therapeut. Research 9:140 (Suppl. 35) 1967. 7. Hart, L. M.: Ibid., p. 179. 8. Nichols, M. M.: Ibid., p. 184. 9. Young, R. J. and Garrett, R. L.: J. Nutrition 81:321, 1963.

in stooling

Stooling problems and perianal dermatitis are minimized by the presence of lactose. A low renal solute load assures ample expendable water reserves to meet stress situations. Adequate amoun of all-known essential vitamins and 8 mg. of iron are included per diluted quart.



Optimil
Optimil

Optimil®, an optimum nutrition infant formula, from Carnatic

MAILBAG

I have noticed in your recent issues of *Michigan Medicine* repeated references to the AMA and its programs. Thank you for your efforts.

F. J. L. Blasingame, M.D.
AMA Executive Vive-President

Many United States doctors have given some of their time and talent to short term missionary type work in recent years. It is no longer a particularly unique endeavor. My message is therefore not one of a new discovery, but rather to endorse a seven-year-old project — S.S. Hope.

The ship was in Cartegena, Colombia from early February 1967 until December 8, 1967. From August 13 until October 15 they endured my presence aboard (and ashore). It is difficult for me to imagine a better vacation.

The ingredients of a satisfactory vacation were all there. The basic requirement is a change from the usual routine. The ship and the city provided that. In orthopedic surgery, as in most of the specialties, time was fairly evenly divided between the hospital ship itself and Hospital Santa Clara of Cartegena University Medical School. The organization and administration of the ship as a functioning hospital were virtually unblemished, but in many respects different from Saginaw General Hospital. It is no problem to practice good medicine aboard. Hospital Santa Clara, burdened with almost unbelievable financial problems, provided a fascinating experience in a different sort of practice.

People, however, are what really produce the perfection. The regular personnel (i.e., everybody except the doctors who rotate every two months as I did) are uniformly both delightful and competent. They practically whistle while they work. The nurses, lab technicians, X-ray technicians, dietitians, etc. are all highly selected people of great talent. In addition to that, it was my good fortune to be associated with the only native, orthopedic resident of Hospital Santa Clara. He is a very bright young man who fortunately had taught himself English sufficiently well that we could communicate quite easily. Had we depended on my Spanish, we'd have been reduced practically to salutations.

There was time for some sight seeing, some swimming (fantastic snorkeling in clear water with coral and tropical fish), a little golf, and other things to eliminate ennui. All in all it was the compleat vacation: enough work to feel useful, enough diversion to be interesting. No physician could spend two months better.

—John O. Goodsell, M.D.
Saginaw

The article in *Michigan Medicine* about the Midland Hospital program to help develop family practice physicians (September issue) has produced a rather surprising response. I have had quite a number of letters from around Michigan in response to the article and several from various places around the country as far as Texas and California in response to the article in the *AMA News.* I've received one inquiry from a young medical officer who gets out of the service next July who is interested in getting into this type of program.

A little publicity really goes a long way!

Thanks very much for all your interest and all your help.

Sincerely,

Robert E. Bowsher, M.D.
Director of Medical Education
Midland Hospital

On behalf of our City of Wayne Museum, and those who use our resources, we wish to thank you for the copy of *A Century of Service in Medicine* which we received recently.

This is a fine addition to our Michigan history, and a most attractive book.

Wayne City Historical Museum
Mildred Hanchett
Director

In Unity — Strength

"It is my conviction that harmony is essential to the overall effectiveness of our profession, both in public campaigns and in our principal objective of patient care. And harmony and active cooperation are necessary not only within our profession — among specialty groups, individual and group practitioners, educators, hospital-employed physicians; but also between physicians and all other members of the health team — dentists, nurses, allied professions and occupations, pharmacists and pharmaceutical manufacturers and personnel of the health insurance industry and the prepayment plans."

—Milford O. Rouse, M.D.
AMA President

Statute Is Quoted Regarding Info Sought On Birth, Death Reports

The new forms for births and deaths require physicians to provide additional information and some questions have been raised about the legality of such disclosures of confidential information.

The following is provided for MSMS members by the MSMS legal counsel:

"Due to an increased demand for statistical data in the socio-economic field from both the federal and state governments, the following statute is quoted:

" 'MSA, Sec. 14.57 (3), as amended, provides as follows:

Sec. 3. The furnishing of information, records, reports, statements, notes, memoranda or other data voluntarily to the state health commissioner or his authorized representative, or to any person, agency or organization duly designated as a medical research project, shall not subject any physician, hospital, sanatorium, rest home, nursing home or other person or agency furnishing such information, records, reports, statements, notes, memoranda or other data to liability in any action for damages or other relief, and shall not be deemed to be the wilful betrayal of a professional secret or the violation of any confidential relationship.' "

Thought Starters

Nothing can come out of an artist that is not in the man.

H. L. Mencken

Plans are the dreams of the reasonable.

Feuchtersleben

Freedom from the desire for an answer is essential to the understanding of a problem.

J. Krishnamurti

The worst tempered people I've ever met were people who knew they were wrong.

Wilson Mizner

Always imitate the behavior of the winners when you lose.

George Meredith

Unquestionably, there is progress. The average American now pays out twice as much in taxes as he formerly got in wages.

—Mencken

One by one
the family's downed
Because the
G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

Explains Why Professional And Public Liability Insurance is Needed

This article is reprinted with permission from Volume XI, No. 3 of The Doctor and The Law, published by the Student American Medical Association.

Generally speaking, malpractice, or professional liability, insurance obligates the company to pay damages for which the physician has become liable as a result of injury arising out of malpractice, error, or mistake in performing or failing to perform a professional service. General liability insurance, or casualty insurance, on the other hand, usually specifically excludes injuries due to the rendering of professional services. An injury to a patient in the physician's office may raise the question of which carrier must pay the damages. The physician will probably be reimbursed by one policy or the other but the companies themselves are vitally concerned as to which one must pay.

In *Hazard* v. *Aetna Casualty and Surety Company,* 253 F Supp. 845, the plaintiff, a polio victim, fell and injured himself when he shifted his position on a stool in a physician's treatment room. The question arose as to whether the physician's casualty insurance or his professional liability insurance covered the injuries sustained. The court got out of trouble by noting that if one thing is certain in this case it is that there is a gray area lying at the fringes of each policy where a given accident may be seen as the result of either the ordinary negligence of a property owner or the improper rendering of, or failure to render, professional care. The court said that in this case both insurance carriers were defending and that if damages are awarded "the court and jury will be able to determine, on the basis of all the evidence adduced at a full trial, exactly how the accident occured and whether the professional liability insurer or the public liability insurer or both are obligated to pay the judgement."

In a somewhat similar case *(American Policyholders Insurance Company* v. *Michota.* 103 NE2d 817) the professional liability carrier asked for a declaratory judgement as to its liability for a claim for injuries by a chiropodist's patient in a fall from a treatment chair. The patient fell when, in following the chiropodist's instruction, she attempted to sit in a metal hydraulic chair designed for the occupancy of patients. The chair was unlocked and it rotated suddenly, causing her to lose her balance. The policy in question covered injuries arising during the course of professional services, not just as a result of failure to exercise the proper standard of professional skill. Maintaining the treatment chair in a proper and safe condition for the accommodation of patients was a service or duty directly connected with the practice of the defendant's profession as a chiropodist. Since the relationship of doctor and patient was clearly established, the court held that the injury resulted from the rendering of a professional service.

The same reasoning was followed in *Messer* v. *Estate of Shannon,* 397 P 2d 846. An osteopath's casualty insurance policy excluded injuries due to malpractice error, negligence, or mistake committed in the performance or omission of a professional service. According to the evidence, the osteopath was giving the patient a manipulation at the time the accident occurred. It was apparently the result of a defective safety catch on the table. The table was especially designed for osteopathic treatments and it, therefore, constituted "professional equipment." The policy's exclusion of professional liability was not restricted to malpractice, the court pointed out. It also excluded liability for any negligence committed in the performance of "professional services." The casualty insurance carrier was found not liable.

The most recent case on this subject depended upon the nature of the act of a student nurse at an infirmary in performing a hypodermic injection. Was this an act "of professional nature" so as not to be covered by a general liability insurance policy? A patient who had sustained nerve degeneration and loss of control of his right foot as the result of an injection sued the general liability carrier for damages. The policy excluded liability for injuries due to medical or surgical services or treatment, or any service of a professional nature. The patient contended that although the giving of an injection may be an act of a professional nature under some circumstances, it was administrative negligence, as distinguished from professional negligence, for the infirmary (which hired the nurse) to permit the student nurse to give the injection or to administer it in an improper manner. The injection was given in the presence of a surgeon and a supervisor of nurses. The Court of Appeals for the fifth circuit found in favor of the general liability insurance carrier. It is the act itself, said the court, not the title or character of the person performing it, that determines whether it is of a professional nature. This act certainly was of such nature.

Obviously a physician who maintains an office should protect himself by purchasing both professional and public liability insurance.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.

Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. Th age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy whe relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (su as abdominal cramps and bloating) breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma breast changes (tenderness, enlarg ment and secretion), change in wei (increase or decrease), changes in cervical erosion and cervical secret suppression of lactation when giv immediately postpartum, cholesta jaundice, migraine, rash (allergic), rise in blood pressure in susceptib individuals, mental depression.

Although the following side effect have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, chan in libido, changes in appetite, cysti like syndrome, headache, nervous dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema no sum, hemorrhagic eruption, itchi

The following occurrences have be observed in users of oral contracep tives (a cause and effect relationsh has been neither established nor proved): thrombophlebitis, pulmo embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine a decrease in T^3 values), metyrapon test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC.,PALO ALTO, CALIF.

Here's why Norinyl-1 makes medical sense.

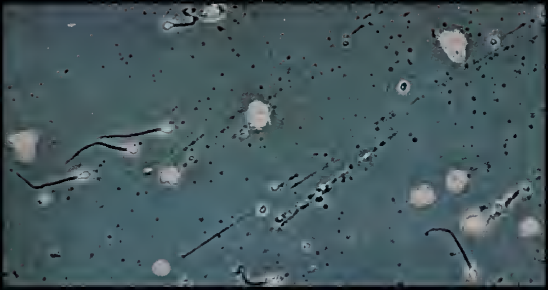
The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

Untreated Patient

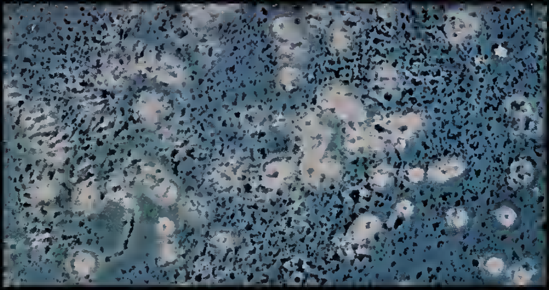
Norinyl-1 Patient

Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

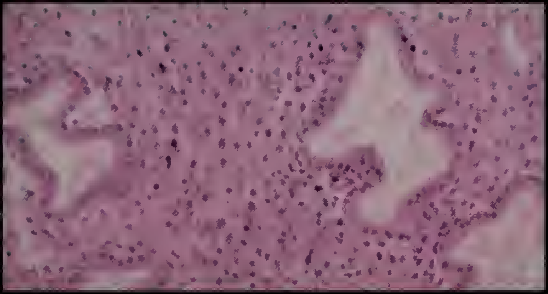
Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



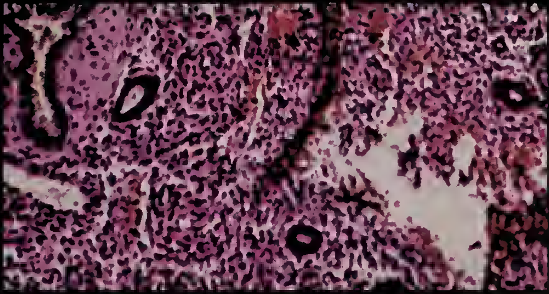
Spermatozoa appear healthy, active, freemoving.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

Night Leg Cramps . . . Unwelcome Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]

now . . . specific therapy for night leg cramps

Walker
QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

Liability Insurance Premium Rates Rise

The rising cost of malpractice claims across the country is forcing a general increase in premiums in many states for physicians' and surgeons' professional liability insurance, a national insurance ratemaking organization said today.

The National Bureau of Casualty Underwriters —which determines premium rates on professional liability insurance for its affiliated companies— announced that rates are being revised in 30 states and the District of Columbia.

The rate level in Michigan was increased 20 per cent.

The NBCU also announced a new classification which will include anesthesiologists, neurosurgeons, obstetricians - gynecologists, orthopedists, plastic surgeons, and otolaryngologists who perform plastic surgery. These specialists will pay higher rates than would have applied if this change had not taken place.

In the five year period from 1959 through 1963, the NBCU pointed out, Bureau companies sustained large underwriting losses on professional liability coverages for both physicians and surgeons.

On the physician classes, losses and company operating expenses amounted to $140 for each $100 in premiums during 1959-1963. This means that companies sustained an underwriting loss of $40 for each $100 of premiums.

On the surgeon classes, losses and expenses totaled $151 for each $100 in premiums during the same period, resulting in an underwriting loss of $51 for each $100 of premiums.

The NBCU said that, in view of the extremely adverse experience in these lines, these rate revisions must be considered "moderate."

Rouse, at Flint, Discusses Physician Income

AMA President Milford O. Rouse, M.D., speaking to the Genesee County Medical Society, criticized some recent Washington news articles which, using new Bureau of Labor statistics, commented on the rapid rise in doctor's fees.

The Bureau of Labor claimed that physician's fees had risen 8.9 per cent from August, 1966, to August, 1967.

Articles based on the statistics "did not specify whether they were talking about total income or per item fee," Doctor Rouse said. "And there is a difference."

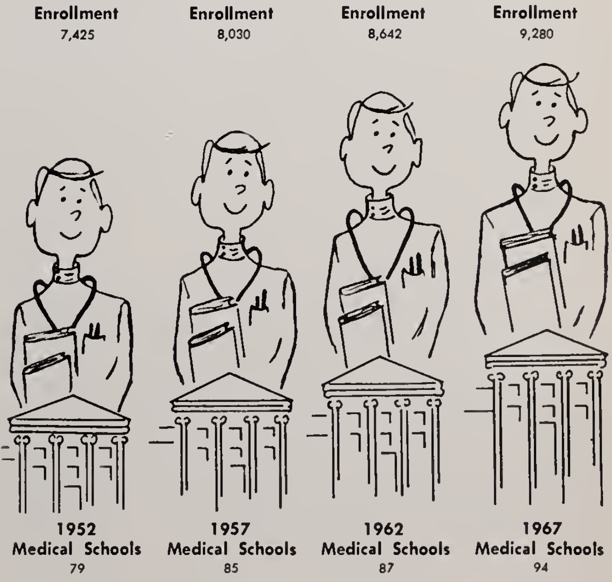
"Certainly," Doctor Rouse said, "the total income of an individual doctor probably has increased moderately, but only in keeping with the constant rise in the cost of living."

Main cause behind the rise in physician income, Doctor Rouse observed, is government health services which have paid the doctor's fee for low-income patients, who the doctor served without charge in the past.

The AMA president called the average physician's annual income of approximately $25,000 a "very modest, equitable comparison with that of the other professions."

Doctor Rouse called upon labor and government to "share with the medical profession the responsibility to hold down to a minimum any rise in medical costs in every way possible."

MED SCHOOL ENROLLMENTS CLIMB



Social Security Official Explains Amendments; Some Become Effective This Month

BY ROGER W. SEAMON, DISTRICT MANAGER
SOCIAL SECURITY ADMINISTRATION
DISTRICT OFFICE, LANSING

Editor's Note: Major changes in the Social Security Law, signed by the President in January, were explained in the February issue. Many physicians have continued to raise questions about some of the new amendments, so another article is offered this month. MSMS members are urged to save this following article, and also to go back and clip out pages 282, 283 and 286 in the February issue of Michigan Medicine.

The changes in the Social Security law signed by President Johnson on January 2, authorized a benefit increase of at least 13% in the social security checks of approximately 24 million social security beneficiaries. Some beneficiaries will receive more than a 13% increase. For example the minimum benefit for workers retiring at age 65 is increased from $44 to $55. The first increased benefit checks will be payable early in March 1968.

RETIREMENT AND SURVIVORS PROVISIONS

These amendments also will enable beneficiaries who continue to work to make more money and still draw some or all of their social security benefits. The amount of money a person can earn in a year and still draw all his social security benefits has been raised. Beginning with 1968 a person who makes as much as $1680 can still collect all of his social security benefits for the year. Even if he earns considerably more than that he may still draw some benefits. Regardless of how high his earnings are for a year, he would still receive a social security benefit for any month in which he did not earn more than $140 in wages and was not active in self-employment.

The new social security amendments also changed the conditions for determining when a child can receive benefits upon the social security account of a working mother. Until now a child was considered dependent upon his mother (and therefore eligible for monthly benefits when she died, retired or became disabled) only if his mother was actually supporting the child or if she had worked under social security for at least 1½ years out of the last 3 years before her death, retirement or disability. The amendments eliminate the support and the recent work requirement.

Beginning with the checks in March 1968, benefits are payable to the child of a woman worker who has died, retired or become entitled to social security disability benefits if his mother has accumulated enough social security credits to be "fully insured," whether or not these credits were for recent work under social security.

DISABILITY PROVISIONS

Another very important change in the law makes it possible for the disabled widow or dependent widower of a deceased worker to receive disability benefits beginning at age 50. Under the old law a widow could not get social security benefits until she reached age 60, unless she had in her care a child who was entitled to payments based on her husband's earnings. Now, a widow whose husband had worked long enough under social security can be eligible for monthly benefits as early as age 50 if she is severely disabled. However, she can be eligible for these disabled widows benefits only if her disability started before or within 7 years after her husband's death, or within 7 years after the period when she received benefits as a widow with minor children.

Another change in the disability provisions changed the amount of work credits which a young disabled person needs in order to qualify for social security disability payments. In the past applicants for disability benefits had to have work credits for at least 5 out of the 10 years before becoming disabled. Now, workers becoming disabled before age 31 need less work credit. The required work varies from 1½ years up to 5 years, depending upon the applicant's age at the time of onset of disability.

FINANCING

The amendments also changed some of the provisions governing the financing of the program. Under the new law the contribution rates remain the same for 1968, 4.4% for employers and employees and 6.4% for self-employed people. Next year the rate will be increased to 4.9% for self-employed people.

Beginning with 1968, earnings up to $7800 a year are subject to social security contributions and will also count toward social security benefits. Therefore the one out of four people who earns over $6600 a year will be paying social security contributions on up to $1200 more of his annual earnings. However, those who pay at this higher rate will receive substantially higher benefits, in addition to getting credit for the 13% increase. For example, a person who is 50 in 1968 and will pay social security contributions on earnings of $7800 a year for only 15 years will collect a retirement benefit of $188.80 per month. This compares with $155 per month which he would have collected under the old law, an increase of 21.8%.

MEDICARE

A substantial number of changes were made in the Medicare program. One of the more important is that now a Medicare beneficiary can make a claim for Part B reimbursement for doctor's services based upon an *itemized* bill. In other words it is no longer necessary that the Medicare beneficiary have paid the doctor bill before claiming Part B Medicare reimbursement. Of course the two alternate claims methods authorized by the original Medicare legislation in 1965 are still in force: the assignment method whereby the doctor submits the claim directly to the Medicare carrier and receives the payment direct from that carrier and the request for payment method by the Medicare beneficiary on the basis of itemized, receipted bills.

The new law also eliminates the requirement that there be a physician's certification to the medical necessity for admission to general hospitals. It also eliminates the outpatient hospital services certification requirement. These changes do not alter the basic concept that Medicare reimbursement will be made for only medically necessary covered items and services. They do, however, recognize the fact that patients are admitted to hospitals only on a physician's order, and the requirement that the hospital obtain written certification of this fact resulted in largely unneccessary paper work. Physician certification is retained for payment of services by psychiatric and tuberculosis hospitals, extended care facilities and home health agencies. The requirement for physician certification after inpatient hospital services have been furnished over a period of time is also retained.

Beginning January 1, 1968 a person covered under the hospital insurance part of Medicare will be eligible for 60 additional days of care partly paid for by Medicare. This is a "lifetime reserve" that can be drawn upon after the beneficiary has used up the 90 days in a "spell of illness." During these additional days, Medicare will pay all but $20 of the covered hospital expenses.

Some of the other changes in the Medicare provisions include.

a. Certain non-routine services of podiatrists or surgical chiropodists are covered under Part B effective January 1, 1968. Diagnosis and treatment of flat feet or partial dislocations are not covered.
b. Purchase of durable medical equipment in certain circumstances.
c. Coverage of outpatient physical therapy services has been expanded to include not only participating hospitals, extended care facilities and home health agencies, but also some clinics, rehabilitation agencies and public health agencies which meet certain conditions.
d. Portable X-ray services performed in a beneficiary's home by a non-physician X-ray operator are now covered by Part B if the operator performs the services under the general direction of a physician, and the tests are performed on a physician's written authorization and they must be read by a physician.
e. All procedures to determine the refractive state of the eyes performed during an eye examination are now *excluded,* even if provided in connection with furnishing prosthetic lenses. The exclusion applies to refractions performed by ophthalmologists, as well as other physicians and even when the total examination is for the treatment or diagnosis of eye disease or injury.
f. There is now a time limit of filing claims for medical insurance reimbursement. Claims for Part B reimbursement related to services provided by doctors in July, August or September 1966 will have to be filed by March 31, 1968. Claims for services in the period from October 1, 1966 through September 30, 1967 must be filed by December 31, 1968.

The premium which Medicare beneficiaries pay for their Part B medical insurance will be raised from the current rate of $3 to $4 per month in April 1968. This increase will be used to finance the extra expenditures due to the expanded benefits provided under the amended program, more frequent use of covered medical services by the aged, and anticipated increases in physicians' fees. More detailed description of these amendments are contained in pamphlets SSI-1967-1 and SSI-1967-2 which can be obtained from your social security office without charge.

An anorectic will help her lose weight—but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers you a pill plus a program.

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg.
10 mg.
15 mg.

For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

the secret of controlling your weight

Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444

To help you control your weight...

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

AMA DOORS OPEN, INVITES VISITORS

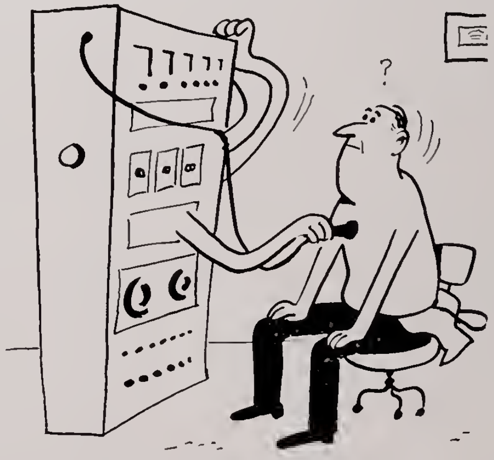
Planning to be in Chicago in the foreseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 North Dearborn just north of the Loop, anytime during office hours—8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

During the third quarter of 1967 nearly 500 persons were conducted on tours of the headquarters offices. This unusually heavy schedule, almost equaling tour attendance for the entire preceding year, indicates increasing personal interest in the AMA by individual physicians. Approximately 60 per cent of those taking tours are physicians. The remainder are medical society personnel, members of the Woman's Auxiliary, medical assistants, those employed in allied health professions and students.



WHAT'S THE PUNCH LINE?

Almost everyone has at times thought he could write and/or draw a cartoon. So here's your chance.

Write a caption for this cartoon situation.

Write the gag line that would spark a smile.

Send it to Publication Committee, 120 West Saginaw, East Lansing, Michigan 48823; and the best caption—or two—will be printed.

Blue Shield Comments On 1967 and New Year

(Note: Following are some excerpts from the Michigan Blue Shield Report to the MSMS Council, January 24. The Report was described by Blue Shield as "a capsulized annual report, highlighting the operations of Michigan Blue Shield during 1967 and providing some summary corporation projections for 1968.—Brooker L. Masters, M.D., Publication Committee Chairman)

Operations

Subscription Income—Regular: Subscription income from our regular Blue Shield programs was $143,477,000 in 1967 compared to $134,058,000 in 1966, an increase of 7.03 percent. Income is projected to be $149,707,000 in 1968 or 4.34% more than in 1967.

Medicare: Gross Medicare bill receipts for 1967 were 1,233,500. The forecast for 1968 is 1,396,700 or a 13.23 percent increase. Based on 1967 year-end estimates, in the first full year of Medicare we will have paid $35,641,424 to physicians (under Blue Shield's Part B responsibility) for 1,063,082 receipts.

Medicaid: Under Medicaid we paid 1,438,921 claims in 1967, for a total of $15,070,256. It is estimated that this volume of claims will increase 11 percent in 1968 with an inestimable increase in payments to providers of service.

Blue Shield's expansion in regular and government programs, was reflected in the increased number of claims submitted for payment during 1967 and the total pay out to providers and subscribers compared to 1966. Following is a comparison of claims and total pay out, plus estimates for 1968.

Total Claims Payments Government and Regular Programs

Year	Claims	Payments
1966	3,367,727	$120,819,000
1967	6,074,823	175,468,680
1968	7,000,000	200,000,000

Providers: The payments reported above were made to 8,331 doctors of medicine, 1,919 doctors of osteopathy, 258 podiatrists, 620 dentists and 421 ambulance companies. Under Medicaid, we also paid for more than 1,500,000 prescriptions filled by more than 2,000 pharmacists.

Enrollment: Regular Blue Shield programs covered a total of 4,382,500 persons in 1967, an increase of 191,329 over the previous year or an increase of 4.57 percent. We are planning for an approximate 5 percent increase in persons covered under regular programs in 1968. Michigan Blue Shield now serves more than 5,492,000 people in all its programs, over half the population of the state.

Manpower: Our increase in business required additional staff. Accordingly, Blue Shield employment rose to 1,145 in 1967, up from 725 at the end of 1966. We foresee a payroll of approximately 1,350 employees by the end of 1968, or an increase of 18.4 percent.

Operating Expense—Regular: Total operating expense for regular business in 1967, including direct expense and those incurred for services performed by Blue Cross for Blue Shield, was $10,889,000 compared to $9,251,000 for 1966. This represents 7.56 percent of 1967 subscription income, compared to an expenditure of 6.9 percent of 1966 income. This year will probably show a higher increase, but in relationship to other Blue Shield Plans' operating expenses, we expect the ratio below to be maintained.

Operating Expense as a Percentage of Benefits — June 30, 1967

All Blue Shield Plans	9.38%
15 Largest Plans	9.66%
Michigan Blue Shield	7.56%

Automobile Negotiations and Allied Efforts Involving New Programs

Labor-management negotiations in the automobile industry involving health care plans were concluded this fall. Benefits negotiated are in keeping with Blue Shield's new programs of extended benefits and variable fees.

While these programs will be effective November 1 of this year for the motors industry, our planning and other implementation activity must be completed in the next several months in order to insure that the program will be operative not only in Michigan but in other states where motors employees work and receive medical care.

Various parts of the new programs are in effect now in steel, rubber and electrical workers' contracts.

Our first shifts of other regular business from M-75 to the new programs are tentatively scheduled to begin on April 1.

Governmental Program Changes

On January 2, the President signed the 1967 Social Security Act Amendments, which contained many changes in the Medicare program.

Perhaps the most essential change in the new law eliminates need for a receipted bill.

Sees Attitude Changing In Nursing Toward The Male Nurse

BY PETER HOHEISEL
OF THE MSMS STAFF

While most of the sexual revolution publicity today goes to the ladies who are taking over formerly all-male careers, there is a counter-revolution taking place in the field of nursing.

A few years ago, it was practically unheard of for a man to want to be a nurse. Today it is still practically unheard of, but not quite.

The change, however, is not so much in numbers but in attitude. Nationally about 1% of registered nurses are men. In Michigan about 2% of students and registered nurses are men.

The real change is in the attitude within the profession itself. In October, more than 9,000 members of the Michigan Nurses Association elected a man, John Wick, BA, MA, RN, to a two-year presidential office.

"Men are very well accepted today in the nursing field," said Mr. Wick, who is also director of Nursing Service at Botsford General Hospital and Ziegler Osteopathic Hospital. "Nursing is an excellent career for a man if he is willing to get graduate training."

A career in nursing generally does not attract young men right from high school. "Very often we get mature men who are around 30," noted Ann Conley, BA, MA, RN, head of undergraduate nursing at Wayne State University. "We get many men out of service who have had satisfying experiences as corpsmen and want to make this their life's work. Some of our students also come from work at mental hospitals as psychiatric aides or attendants."

"There are so many places where men are badly needed," continued Miss Conley. "For example, in some orthopedic services where children are hospitalized — this situation can easily become a woman's world, but children need men too. Some of the other places where men are very much needed are industrial medicine and psychiatric services for children and adolescents."

Where can men go for nurses training? All the state universities and community colleges which have nursing programs are open to men, and many of the hospital programs are open to them. Some of the hospitals do not accept men candidates. For example, Henry Ford, Harper and Deaconness Hospitals in Detroit do not accept men, while Grace, Mercy and Providence do. Also some of the smaller girls colleges around the state would not accept men into their nursing programs.

Is there any difference in the training of male and female nurses? Not substantially or in theory because both have to pass the same state boards. As far as clinical training goes, according to Ann Lardie, RN, Recruitment Coordinator of Nursing Careers for the Michigan League for Nursing, there may be some adjustment. For example, though the men would be trained in theory, they would not actually be involved in post-partum care for mothers in some programs.

HARPER HOSPITAL.

Shown above is one of the two ambulance wagons which Harper Hospital operated in Detroit in the 1880's. The history of the ambulance service is part of the larger hospital story which has now been told by Frank B. Woodford and Phillip P. Mason in a book called **Harper of Detroit.** Published by Wayne State University Press, the book sells for $7.95 and is available at the Handy Shop in Harper Hospital.

MSMS COMMITTEES ARE HARD AT WORK:

Friday, January 5
Michigan Chapter, American Society of Landscape Architects
MSMS Headquarters

Monday, January 8
Ingham County Medical Explorers
MSMS Headquarters

Tuesday, January 9
COMMITTEE ON LEGAL AFFAIRS
MSMS Headquarters
Chairman: Otto K. Engelke, MD, Ann Arbor

Wednesday, January 10
Ingham County Blue Shield
MSMS Headquarters

Michigan Council on Smoking and Health
MSMS Headquarters

JUDICIAL COMMISSION
MSMS Headquarters
Chairman: Donald N. Sweeny, Jr., MD, Detroit

COMMITTEE ON ALCOHOL AND DRUG DEPENDENCE
Canopy Restaurant, Brighton
Chairman: Herbert A. Raskin, MD, Detroit

Thursday, January 11
Ingham County Woman's Auxiliary
MSMS Headquarters

Michigan Partners of the Alliance
MSMS Headquarters

LIAISON COMMITTEE WITH STATE BOARD OF REGSTRATION IN MEDICINE
MSMS Headquarters
Chairman: Kenneth H. Johnson, MD, Lansing

COMMITTEE ON REHABILITATION
MSMS Headquarters
Chairman: Richard W. Pomeroy, MD, Lansing

Thursday, January 18
SUBCOMMITTEE ON LAY EDUCATION (of Maternal Health Committee)
MSMS Headquarters
Chairman: Richard T. Mellis, MD, Kalamazoo

COMMITTEE ON RURAL MEDICAL SERVICE
MSMS Headquarters
Chairman: Robert E. Rice, MD, Greenville

Friday, January 19
Michigan School Health Association
MSMS Headquarters

Tuesday, January 23
COMMITTEE ON MEDICINE AND OSTEOPATHY
MSMS Headquarters
Chairman: John J. Coury, MD, Port Huron

Wednesday, January 24
THE COUNCIL
MSMS Headquarters
Chairman: Robert J. Mason, MD, Birmingham

COUNTY SOCIETIES COMMITTEE
MSMS Headquarters
Chairman: John J. Coury, MD, Port Huron

FINANCE COMMITTEE
MSMS Headquarters
Chairman: Robert K. Whiteley, MD, Detroit

PUBLICATION COMMITTEE
MSMS Headquarters
Chairman: Brooker L. Masters, MD, Fremont

AD HOC COMMITTEE TO STUDY BLUE SHIELD
MSMS Headquarters
Chairman: Kenneth H. Johnson, MD, Lansing

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

Edwin M. Williamson, M.D.
M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

Mead Johnson - pharmaceuticals created for your specialized clinical needs

She relies on your contraceptive advice

She can expect to continue Oracon for years

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

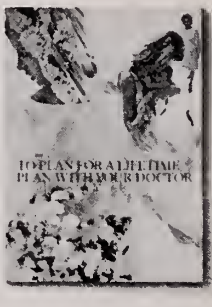
Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

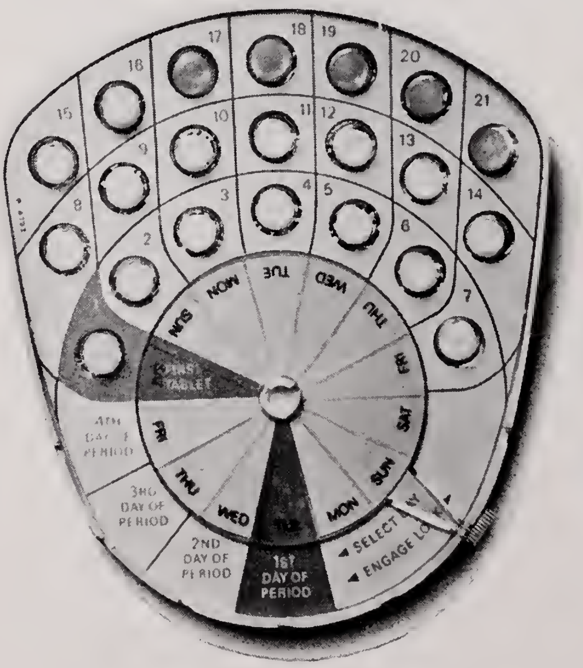
Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.





in the Pakette® dispenser

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Mead Johnson
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IN MEMORIAM

C. E. Boone, M.D., Zeeland

Cornelius E. Boone, M.D., long-time Zeeland physician, died December 31 at the age of 81.

He attended Hope College and the University of Illinois College of Physicians and Surgeons where he received his M.D. degree in 1911. After three years of practice at Olive Center, he served as an Army surgeon in World War I. From 1919 until recent months, he practiced in Zeeland. He had served as chief of Staff of the Zeeland Community Hospital and was also affiliated with the Holland City Hospital, Holland. For 15 years he was an examiner for the Selective Service.

Doctor Boone was a Life Member of MSMS and belonged to the American Legion and the Masonic Lodge.

J. W. Lawson, M.D., Detroit

John W. Lawson, M.D., retired Detroit otolaryngologist, died November 15. He was 74.

Doctor Lawson, who was born in Grand Ledge, Michigan in 1893, served in the military during World War I before entering the University of Michigan Medical School.

He received his M.D. degree in 1928, and did his internship at Harper Hospital, Detroit, 1928-29. After postgraduate training in otolarynology, he began the practice of his specialty in 1930. He was a Diplomate of the American Board of Otolaryngology.

G. R. Pray, M.D., Jackson

George R. Pray, M.D., Jackson general practitioner and a past president of the Jackson County Medical Society, died December 24 at the age of 89.

Graduated from the University of Michigan Medical School in 1900, he interned at University Hospital and did postgraduate work at Chicago Policlinic and Postgraduate. He served as prison physician at Jackson from 1902 until 1913 when he opened his own practice.

A member of Phi Beta Pi, he held various offices in the national organization, including Supreme Secretary, Eastern Praetor, Treasurer, and Supreme Archon (President). He was a 32nd degree Mason.

For nine years he served as a member of Foote Memorial Hospital board of control and was examining physician for the military services for many years.

Doctor Pray was a Life Member of MSMS.

I. L. Sparling, M.D., Northville

Irene L. (Martin) Sparling, M.D., retired Northville general practitioner, died December 27 at the age of 72. Doctor Sparling had practiced in Northville for 40 years. She began practice there in 1925, after her graduation from the University of Michigan Medical School in 1924.

Born in Homer, she did her pre-medical studies at Eastern Michigan College. She was affiliated with Beyers Hospital in Ypsilanti.

She was a member of the Business and Professional Women's Club, Garden Club, Presbyterian Women's Organization, and Senior Citizens.

Doctor Sparling was a Life Member of MSMS and a member of Alpha Epsilon Iota medical fraternity.

E. S. Thornton, M.D., Muskegon

Eugene S. Thornton, M.D., Muskegon surgeon and former member of the MSMS Legislative Committee, died December 28. He was 81.

A member of the State Board of Registration in Medicine for 12 years, he had also served on the State Advisory Board of Health and the State Hospital Commission.

He was a gradute of Wabash College and the University of Michigan Medical School in 1916. Except for the period of World War I when he served as a Captain in the Medical Corps, Doctor Thornton practiced in Muskegon from 1916 until his retirement. He had served as chief of surgery, chief of gynecology, and as chief of staff for many years at Mercy Hospital and was a consultant in surgery to Hackley Hospital.

Once president of the Muskegon County Medical Society, he was secretary of the group for eight years. He was a member of the Muskegon County Emergency Welfare Commission, a member of the North Muskegon Board of Education for nine years, and had been chairman of the county Democratic Central Committee. He was a past president of the Muskegon Kiwanis Club and a 32nd degree Mason.

Doctor Thornton was a Life Member of MSMS and a Fellow of the American College of Surgeons and the International College of Surgeons.

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

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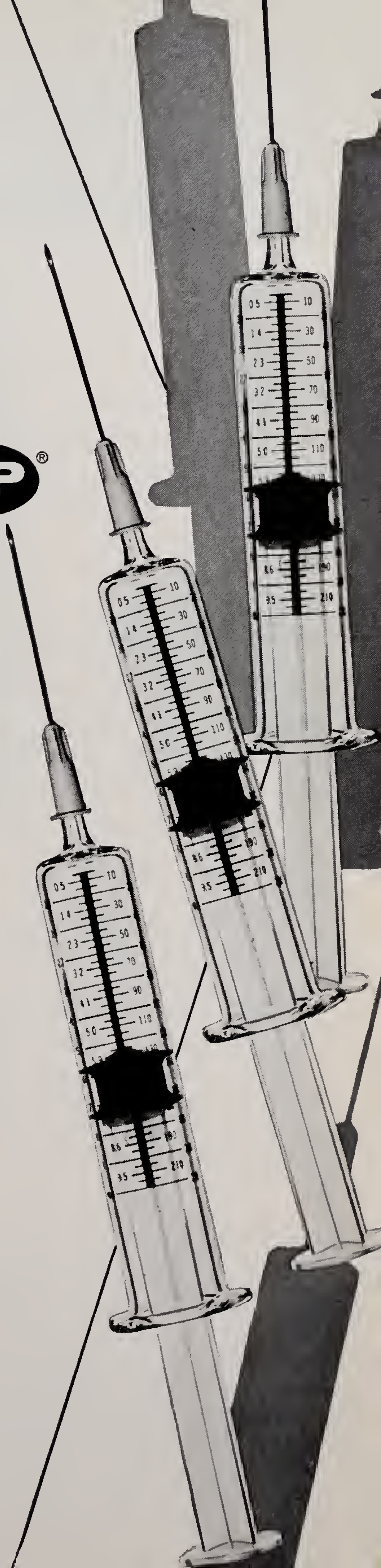

MICHIGAN MEDICINE

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PROCEEDINGS, PAGES 493-496

MSMS members may wish to pull out the four cream-colored pages immediately after the blue breaking-news pages in the middle of this issue. Members may want to read and file the official actions of the recent special meeting of the MSMS House of Delegates.

Pages may be removed easily now from the perfect-binding method used by MICHIGAN MEDICINE.

ABOUT THE COVER

The cover this month calls attention to the guest article on page 455, which was commissioned by the MSMS Committee on Socio-Economics. Two previous articles in the series appeared in 1967. The appropriate design, about "The Medical Profession and the Public: An Examination of Interrelationships," was developed by Dar Davis, graduate art student and art instructor at Michigan State University.

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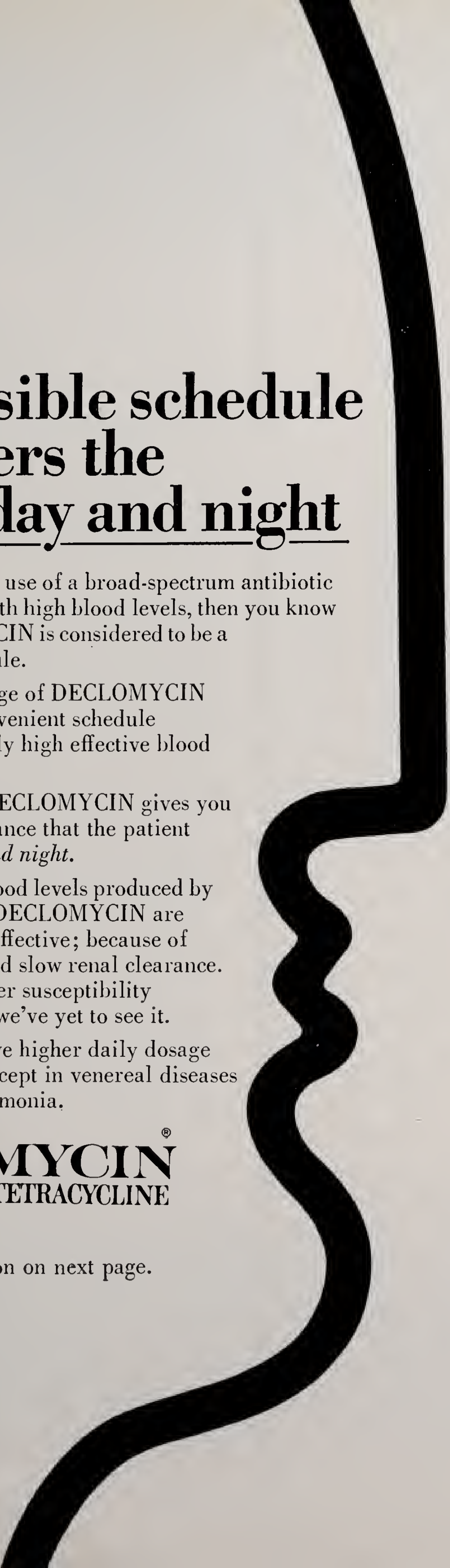
b.i.d.

The sensible schedule that covers the patient day and night



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DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

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Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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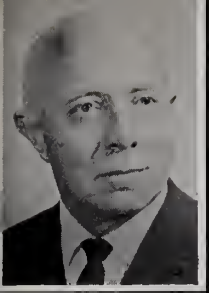

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Why? Why? Why? When? When? When? How? How? How?

Why do governing boards try to operate hospitals without a single board member who is qualified to practice medicine?

Why did the 1962 or 1963 MSMS House of Delegates resolution calling for at least one doctor on every hospital board have virtually no impact?

Why? Why? Why?

* * *

When did the pattern of hospital operation develop with physicians deliberately excluded from the hospital boards of directors?

When did your local hospital board decide not to honor the MSMS resolution of 1962 or the one of 1963?

When? When? When?

* * *

And now, we wonder how will the hospital board members and administration — and the local communities — react to the new recommendation of the reputed National Advisory Commission on Health Manpower? That impartial advisory group, appointed by the President, declares: "Medical and hospital associations should jointly explore means to increase the physician's responsibility for the successful and economical arrangement of hospital operations." Specifically, the recommendation suggests the consideration "of including physicians in the membership of hospital boards of control." The AMA Executive Committee, in commenting on the NACHM recommendation, points out that "this has long been urged by the AMA and would go far toward better management of hospitals."

How can local hospitals ignore both the MSMS resolutions and the recent AMA resolution on the same subject?

How can MSMS members call attention to this void in good hospital planning and operation to their community leaders?

How? How? How?

* * *

As president of MSMS, I challenge and urge every MSMS member to let all thinking, reasonable people know that a hospital governing board with no doctor of medicine as a member is just not soundly constituted. □

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

Goiter, A Persistent Medical Enigma

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

Just over 50 years ago, Marine and Kimball reported that they were able to prevent goiter in a large number of children if their diet was supplemented with small quantities of iodine.

Subsequent studies confirmed the value of these observations and it was thought that the goiter problem had been solved with the exception of a small percentage due to hyperthyroidism or Graves disease and various types of neoplasia. So-called lymphocytic thyroiditis had been described but at least in this country, it was considered of minor importance. The incidence of thyroid enlargement unassociated with other evidence of thyroid malfunction decreased remarkably over the next few decades.

The once familiar sight of the patient with a huge tumor the size of a baseball under his chin became a distinct rarity.

HOWEVER, THE PROBLEM obviously was not completely solved. It soon became apparent that iodine was a double-edged sword. As a supplement to the diet it certainly was beneficial in the prevention of so-called endemic goiter. When given in slightly larger quantities such as that found in many cough syrups or medications for the therapy of the asthmatic, and especially if these were taken over a prolonged period of time at fairly frequent intervals, marked enlargements of the thyroid could occur.

Even though the use of iodized salt became almost, but never completely, universal, surveys as recently completed as the late 1950's and early 1960's show an incidence of goiter of from 3% to more than 10%.

IN THE TECUMSEH study, the incidence was 2.9% in males and 10.2% in females. Nearly 40% of the families studied did not use iodized salt so the question could be asked, 'Why was the incidence of goiter so small?' Similar studies revealed like findings in many parts of the world.

Biopsy studies in areas as diverse as Boston, Glasgow, and Goteborg revealed that more than 30% of goiters in all ages were the result of chronic lymphocytic thyroiditis. This condition is generally considered to be benign although occasionally it does progress to thyroid deficiency.

Statistically it was shown that many of these patients had an elevated circulating thyroid antibody level and some a transient elevation of protein bound iodine. Unlike many other goiters, response to therapy with thyroid was not very spectacular. Decrease in size of the gland was seldom dramatic and often no change resulted. Some authors now consider chronic lymphocytic thyroiditis to be the single, most common cause of enlargement of the gland in children and young adults in this country.

GOITER CONTINUES to be a problem throughout the world. Its geographical distribution is widespread and does not spare the affluent areas in deference to the less advantaged. Iodine deficiency still remains a problem in some areas but chronic thyroiditis, the exact etiology of which remains unknown, would appear to be the explanation for many. In addition, chronic medication with goitrogenic agents must be taken into account as well as the more uncommon hereditable disorders of hormone synthesis.

Finally, neoplasms of the thyroid must always enter the differential diagnosis and the fact that they are found more frequently in regions of endemic goiter is a further disturbing thought.

Best Wishes! Component Society Leaders

BY ROBERT J. MASON, M.D.
CHAIRMAN, THE MSMS COUNCIL

New officers are now in harness for the 55 component medical societies and the nominating committees already are watching for the potential 1969 leaders.

May I quickly wish the new officers every success possible. May I also invite them to call upon their MSMS district councilors and MSMS staff members for assistance and advice.

The rank-and-file members are grateful to the physicians who do accept leadership responsi-

Continued on Page 441

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Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

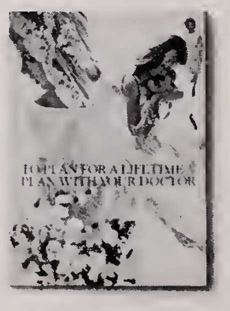
Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

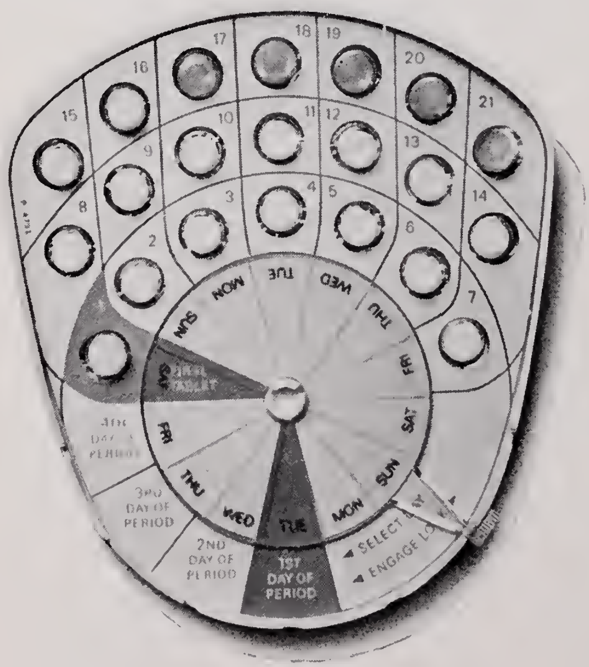
Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.





in the Pakette® dispenser

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets, 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg Tablets

Mead Johnson
LABORATORIES

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bilities to make the component societies effective. And the loyalty of associates can be a major factor in the success of leaders.

Each of the leaders across the state among the component groups is indeed different. Each has individual traits, each is in a unique situation, and each is working with a component society that has different group characteristics.

ONCE CHOSEN FOR A leadership role, the officer or chairman makes the necessary preparations, and makes the sacrifices necessary to function throughout the year.

The MSMS Council will provide information to help the county leaders. And many MSMS officers, chairmen and staff members will help provide enthusiasm and inspiration.

Earned leadership is leadership at its best, and in general that is what we see in medical organizations. Leadership is not achieved in the "bargain basement." It is learned and earned over the years — and the skills and mental attitudes must be improved each day through constant effort to improve and grow.

MSMS AND THE AMA depend upon the component medical society leaders — and so do individuals in the local community, county, state, nation and world.

Yes, the demands and responsibilities are heavy — but democratic leadership can accomplish much and inspire many.

Best wishes! ☐

For Public Service

"These 10 Michigan physicians are typical of many who are presidents of local boards of education, civic service clubs, voluntary associations, etc."

That declaration was made by MSMS President B. M. Harris, M.D., when MSMS recently announced that it had established a new award for Michigan physicians who serve as presidents of state-wide, non-medical organizations.

The first 10 awards were made at the recent MSMS Annual Awards Luncheon in Detroit at part of the First Annual Conference on Michigan Health Planning.

The new award will be known as the "MSMS Flag Award," and recognizes the men "in recognition of his meritorius public service as president of . . ." The award, Doctor Harris explained, cites Michigan doctors of medicine "for leadership provided to state-wide groups in such areas as education, welfare, youth, science, health and others."

The new MSMS award both recognizes contributions by many and also challenges all physicians to contribute leadership to important state, national and local groups. MSMS encourages local county medical societies to provide recognition to their members who assume leadership roles in many community organizations.

(The names of the 10 physicians appear in a news article on pages 503 and 504.) ☐

M.D. Plays Major Role In Home Health Services

GUEST EDITORIAL

BY JOHN A. COWAN, M.D., CHIEF

STATE DIVISION OF ADULT HEALTH

For the development of home health services, the physicians' role of professional leadership is as important to the patient as it is in the hospital, nursing home, extended care facility, clinic, or office. The physician is the key to the success of the plan of treatment for the patient.

Ideally, the initial decision to recommend a patient for home health services should be made by the physician. Related factors to be considered are a feasible home environment for the care of the patient, a willingness on the part of the family to take part in the care of the patient, and of the patient to be cared for at home.

The physicians' role is a multifaceted one. As head of the medical care team, he has the responsibility for the patient's diagnosis, treatment and rehabilitation, if necessary, and must request such services as he feels are needed. In addition to providing medical services to the patient, the physician directs and advises the members of the medical care team: the nurse, physical, occupational, or speech therapists; the home health aide, or representatives of other agencies providing services necessary in the patient's treatment.

HOME HEALTH SERVICES that are successfully coordinated provide continuity in total patient care. Care provided to the patient in the home usually speeds recovery. Self-confidence and independence seem to run higher when an ill patient is in familiar home surroundings and with family and friends. The desirability of home care

Continued on Page 444

An anorectic will help her lose weight–but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers you a pill plus a program.

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

FRONT SIDE

DESBUTAL 15 Gradumet

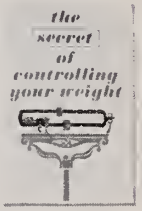
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

FRONT SIDE

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444

To
help you
control your
weight...

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT
801444

was lauded by the 1965 MSMS House of Delegates when it adopted Resolution 40.

Patients with arthritis, multiple sclerosis, arteriosclerosis, strokes, polio, muscular dystrophy, and diabetes are among those who may benefit from home health services. These conditions and diseases affect the aged, an ever-growing population, whose health needs already are a challenge. However, age alone is not the determinant of who can benefit from home health services.

Home health services can be advantageous for all age groups, the young, as well as the old. The young, for example, may suffer emotional trauma when removed from their families for long hospital stays.

ALTHOUGH 71 COUNTIES in Michigan have home health agencies which provide two or more of the services, nevertheless, many people in Michigan still are not receiving home health care that they may need. Some patients are eligible for payment of services through Medicare and Medicaid; all patients are eligible for service regardless of their ability to pay.

Surveys have shown that although home health services are available, many persons in need of care do not know of the existence of such services. Although the success of the home health service program in any community depends in large measure upon the ability and the enthusiasm of the health service professionals, and the support of business, social, and civic groups, its success depends primarily upon the cooperation and appropriate referral from the physician.

Further information regarding home health services in your county may be obtained from your local health department or visiting nurse association. ☐

Auxiliaries Help Recruit

BY MRS. W. G. GAMBLE, JR.
PRESIDENT, WOMAN'S AUXILIARY

Meeting the health needs of the future through providing sufficient health manpower is perhaps the medical profession's greatest challenge, and it is a challenge that the Auxiliary whole-heartedly embraces.

Our efforts in this area have been numerous—last year the Auxiliary, through the county auxiliaries, distributed thousands of copies of *Horizons Unlimited* and other publications designed to encourage young men and women to enter the health field. We have a combined fund of nearly

Say you saw it in Michigan Medicine

$20,000 representing scholarships, loans, and loans outstanding to assist financially people preparing for health careers.

OUR MEMBERS have manned the Health Careers Mobile in its journeys throughout the state. They have helped with the organization of health career clubs in high schools all over Michigan. They have assisted with health career days in many counties in the Lower and Upper Peninsulas. They participated in the Michigan State Medical Society's project "Operation Billboard" to place 200 billboards throughout Michigan to promote health careers.

In December the Auxiliary took part in the First Annual Michigan Institute on Health Careers sponsored by the Michigan Health Council and related agencies. Intended as an information exchange between guidance counselors and representatives of health careers and persons working with health career recruitment, the conference was said to be extremely informative to all parties concerned.

ALL THESE THINGS the Auxiliary members have done, but their task is now far greater and more encompassing. It is estimated that by 1970 more people will be employed in health careers than in any other field, and one out of every nine high school students must enter a health career to fulfill the coming demand for health care. Our Auxiliary members are cognizant of these facts, and this year they are attempting even greater tasks in order to help fill the present and future need for health care.

Mrs. Jack E. Goodwin, Frankenmuth, is the Auxiliary's state chairman of health careers, and she urges physicians and their wives to remember the three R's of health career recruitment:

Recall adults who have been trained in health careers but who have not been active in the recent past and urge them to take the necessary refresher courses to enable them to begin practice again.

Review the education requirements in each field, realistically evaluating the needs of today and the training and preparation necessary to meet them.

Recruit people of all ages to the health professions and occupations. All methods must be used to make our recruitment efforts more effective. We must continue to use the tools that have been found useful as well as to seek new ideas and procedures that will improve our methods.

BY REMEMBERING AND applying the three R's, Mrs. Goodwin points out, the Auxiliary and the medical profession can further their aims and activities in health career recruitment. However, manpower is also needed for the recruitment effort, and we need the help of all doctors' wives. By working in the Auxiliary's career-recruitment programs and applying the three R's, the challenge of sufficient health manpower can in part be met. ☐

Yes, Write, Write To Your Congressman

BY VERNON V. BASS, M.D.
MDPAC CHAIRMAN

"Congressmen don't pay any attention to letters, do they?"

"Our congressman never votes our way, so why bother?"

"Our congressman always votes our way, so why bother?"

* * *

These are three questions that MSMS officers and staff members hear quite often. And they hear variations of these questions too as they effect the Michigan legislature.

The questions are posed in a recent issue of *Washington Report,* a newsletter of the Chamber of Commerce of the United States.

The Chamber answers are good and will help answer doctors who pose the same issues.

The *Washington Report,* in part, declared:

"Question:

"Congressmen don't pay any attention to letters, do they?

"Answer:

"Conferees heard actual conversations reported in which key legislators used the phrases, 'Well, judging from my mail . . .' or . . . 'My mail is running four-to-one in favor of . . .' to show that legislators do pay attention to their mail.

"They quoted legislators and journalists to emphasize that lawmakers are quick to spot a trend and quick to spot an informed letter-writer — especially one who represents a segment of the constituency they are anxious to please.

"Question:

"Our congressmen always vote our way, so why bother?

"Answer:

"Many provisions inpending legislation are not just black or white. Your congressman needs your opinion and your support. He will be getting opposition pressure too, and he's human.

"Congressional Action Committee members

swapped ideas, points of interest, ways in which the Chamber's legislative information materials (including Washington Dial) are used to keep members informed on breaking developments.

"More local chambers have begun the practice of putting policy positions down in writing for more effective communications. They are also combining communications efforts with trade associations for even more effectiveness.

"The conferences, hopefully, will assist local organizations to key efforts toward becoming effective voices for business and dispel the myth that they are 'only a lonely voice in the wilderness.'"

As an active member of the Saginaw Chamber of Commerce, I know first-hand that the Chamber political action program is effective. I would urge more physicians to participate actively in their own local chamber. ☐

On Writing And Reading Editorials

GUEST EDITORIAL
BY CHARLES SELLERS, M.D.
DETROIT

When an editor writes an editorial and permits its publication, he exposes himself to the various reactions that may arise within the minds of his readers.

On one hand, there may be mis-reading, misinterpretation, cynicism, bias, prejudice and even calumny either inherent or aroused in the minds of some readers.

On the other hand, there may be, on occasion, a certain amount of open-mindedness, understanding, appreciation and even accolade develop in the minds of other readers.

PROBABLY THIS IS true because the editorial writer is a human being and as such may be imbued with certain qualities, opinions and ideas that become apparent or seem to become apparent and result in such a wide range of appraisals. The reader, also being human, may possibly harbor certain feelings, attitudes and convictions that may influence his receptivity of such writings aside from purely subjective considerations.

Some old friends may receive editorials, that might prove to be less than the best, with graciousness and concede that they are acceptable considering our limitations. Such is not the case with most others. We cannot expect leniency from them for they have the privilege of expecting the best.

The writing of an editorial is a many patterned thing evolving around the personality, perception, insight and interest of the author concerning a particular theme or subject. To be worthy of publication, an editorial must of necessity be one man's opinion. It should be grounded on relative truth. It should be clear, concise, imaginative, instructive and above all provocative. It should attempt to arouse consent or dissent in the mind of the reader. If all editorials were innocuous, they would quietly pass into the limbo of the innumerable items that cross our desks and land unread in the round file.

PHYSICIANS ARE individualists, some rugged and some slightly less rugged and more compassionate of their fellowmen. Among the primary attributes of the good physician are a great curiosity about life and the living thereof, tolerance for the opinions of others without becoming too opinionated himself, an inquiring mind and an exceptional ability to formulate quite valid opinions and conclusions based on experience and evidence.

Since individual experience usually is dissimilar and evidence may be interpreted differently by each person, it is natural that editorial writings may arouse diverse reactions, recall various experiences and indicate conflicting evidence to readers with widely varied backgrounds and current interests.

Editorials should not be construed as joint projects. They should not be interpreted as the official voice of the society nor of the publication. They represent the point of view, occasionally tempered by the editorial board, of the individual author whose signature subtends.

Editorial writers have the privilege of an opinion. ☐

3A's of Involvement

BY WALTER F. STREMPEK, M.D., CHIEF
REHABILITATION SERVICES SECTION
DIVISION OF ADULT HEALTH
MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The following guest editorial was written after reviewing the 1967 Public Health Service Review of the "Health Consequences of Smoking."

The fact that there were 48,000 automobile deaths in 1965 in the nation is considered a tragedy.

The fact that there were 300,000 excess deaths associated with smoking in 1965 is viewed with apathy . . . indifference . . . complacency.

There are three levels of involvement: Awareness . . . Acceptance . . . Action. At what depth of involvement are you in the smoking-health issue?

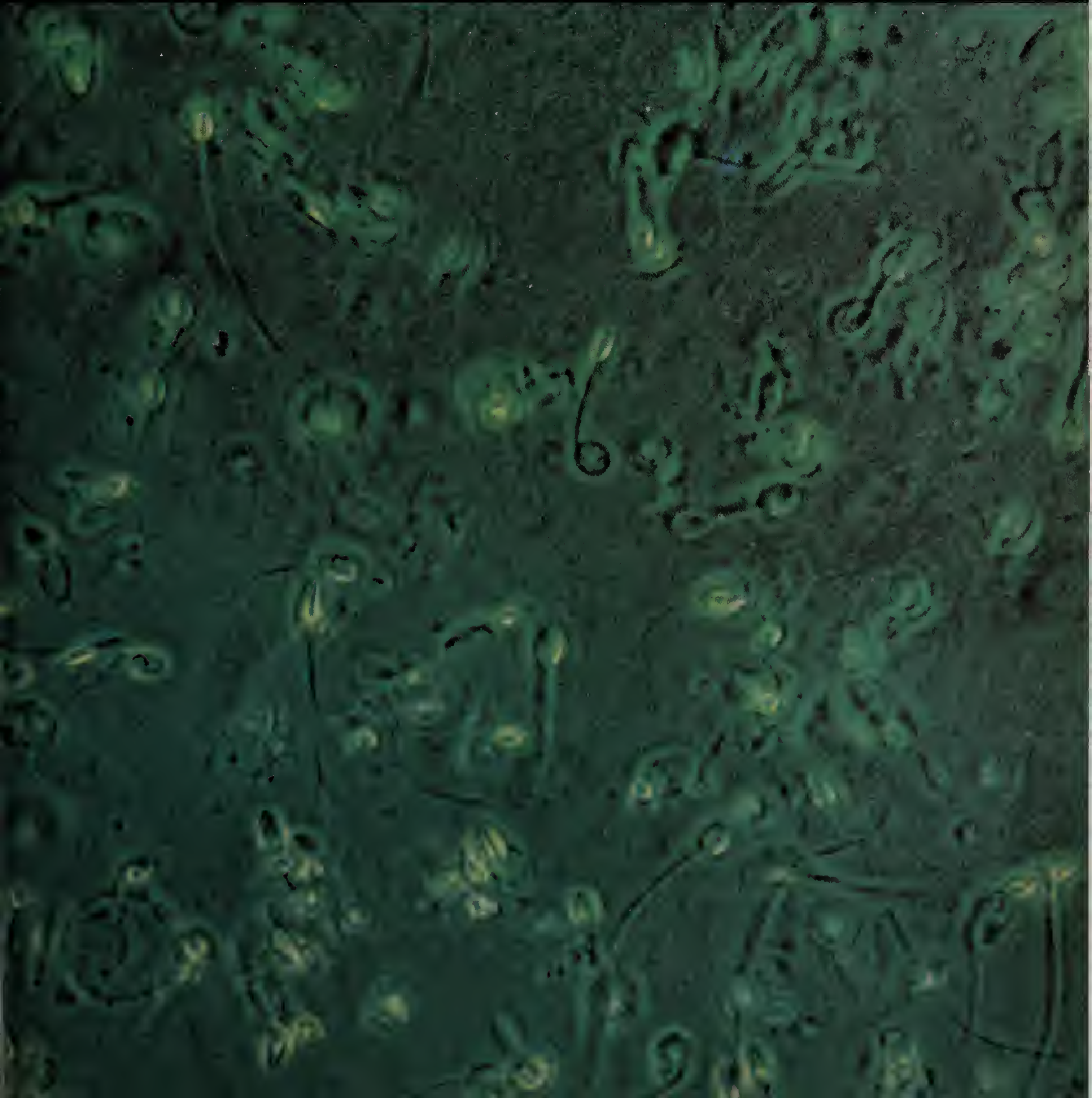
AWARENESS:—The majority of physicians are

Continued on Page 453

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg c̄ mestranol 0.05mg)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. Th age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy wher relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (su as abdominal cramps and bloating breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma breast changes (tenderness, enlarg ment and secretion), change in we (increase or decrease), changes in cervical erosion and cervical secret suppression of lactation when giv immediately postpartum, cholesta jaundice, migraine, rash (allergic) rise in blood pressure in susceptib individuals, mental depression.

Although the following side effect have been reported in users of ora contraceptives, no cause and effec relationship has been established: anovulation post-treatment, premenstrual-like syndrome, char in libido, changes in appetite, cyst like syndrome, headache, nervous dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema n sum, hemorrhagic eruption, itchi

The following occurrences have b observed in users of oral contrace tives (a cause and effect relationsh has been neither established nor proved): thrombophlebitis, pulmo embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepati function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine decrease in T^3 values), metyrapor test, pregnanediol determination

norethindrone — an original steroid from

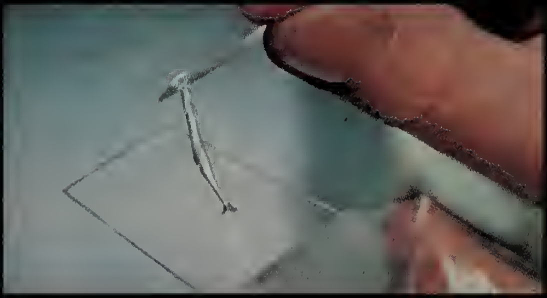
SYNTEX

LABORATORIES INC., PALO ALTO, CALIF

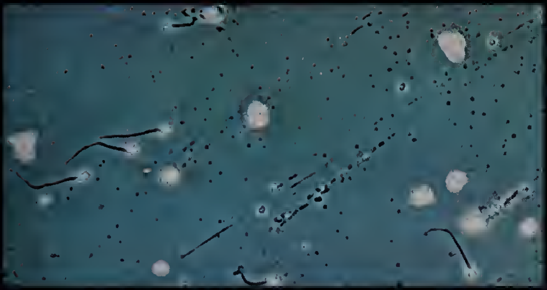
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

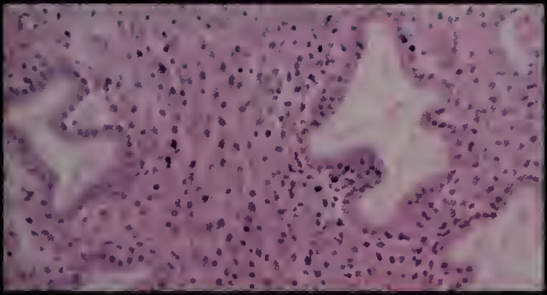
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

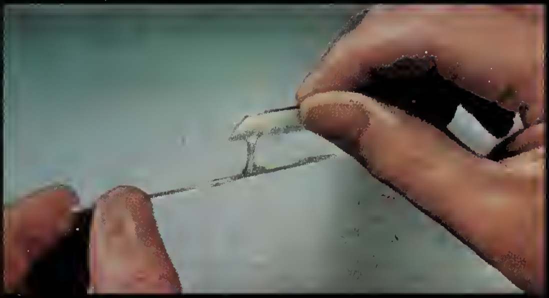


Spermatozoa appear healthy, active, freemoving.

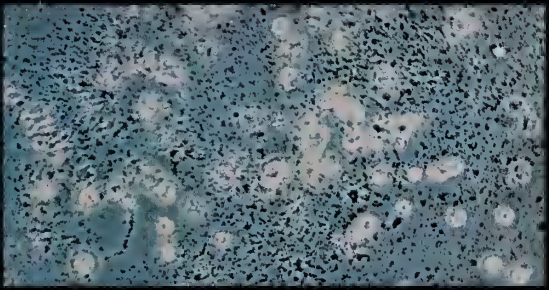


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

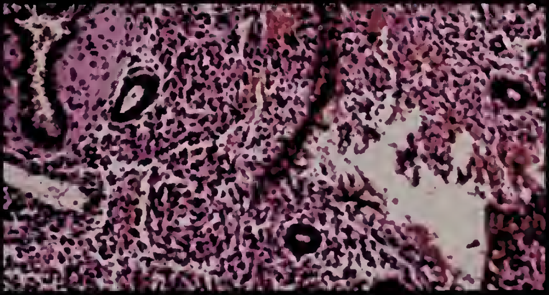
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.

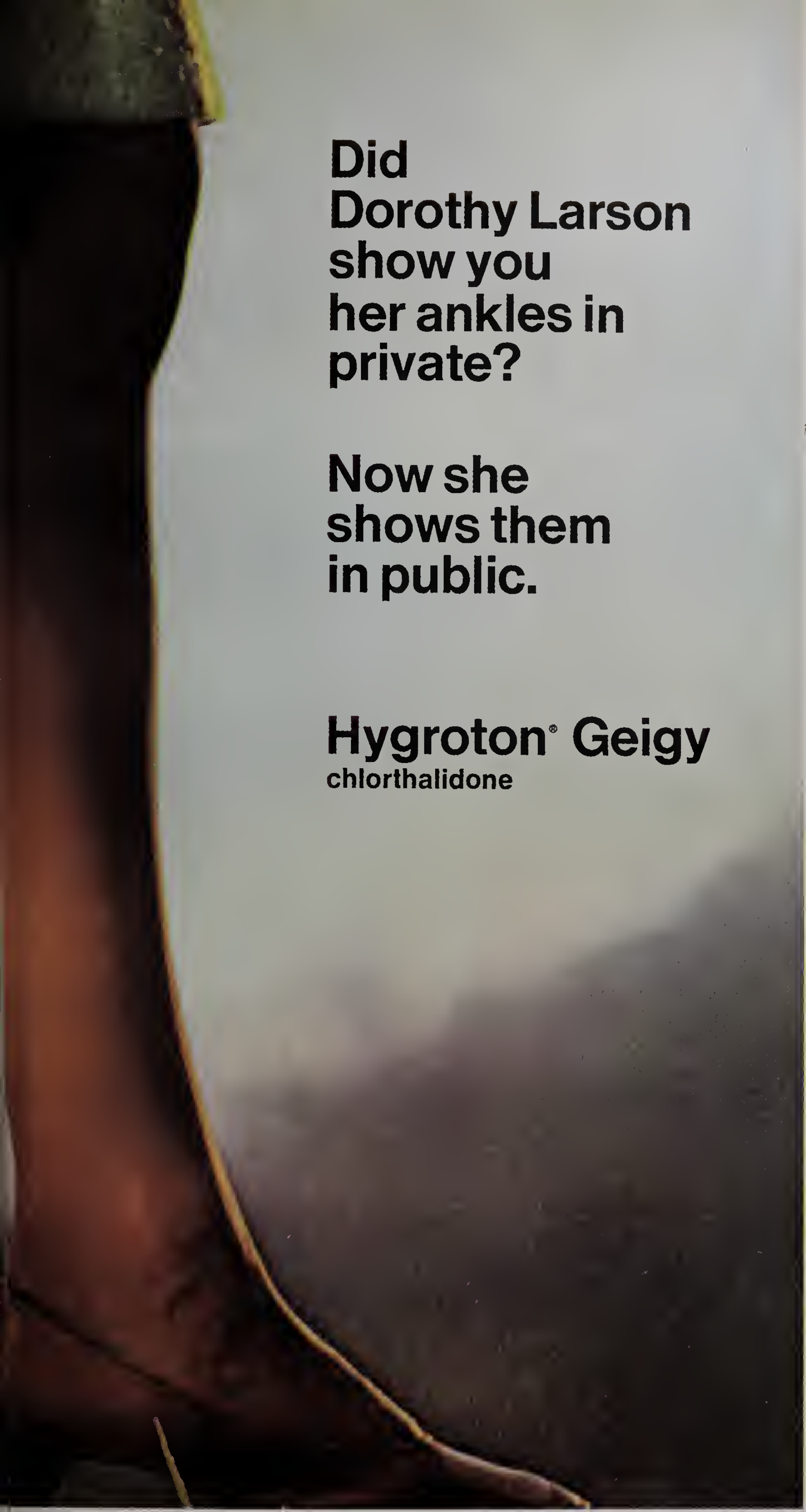


Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg c̄ mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol
may potentiate hypotension
cause of the possibility of p
sion of renal damage, perio
determination of the BUN is
cated. Discontinue if the BL
or liver dysfunction is aggra
Hepatic coma may be preci
Electrolyte imbalance, sodi
or potassium depletion may
If potassium depletion shou
cur during therapy, Hygroto
be discontinued and potass
supplements given, provide



Did Dorothy Larson show you her ankles in private?

Now she shows them in public.

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aware of the innumerable articles and reports which have appeared over more than a decade in the medical literature, lay magazines, newspapers, etc. regarding the cigarette smoking problem. This culminated in "Smoking and Health," a report of an Advisory Committee to the Surgeon General of the Public Health Service, and associated cigarette smoking with higher death rates and death at earlier ages.

Another comprehensive critique of more than 2,000 research studies, "The Health Consequence of Smoking," a Public Health Review, 1967, has also been recently released and is recommended for your perusal.

ACCEPTANCE:—There can be no doubt that many physicians have accepted the evidence which incriminates cigarettes, for they have altered their behavior. A recent survey has revealed that the percentage of physicians smoking cigarettes has declined from 60 percent to 30 percent in recent years. This change in behavior of physicians was noted also in Britain and studies over a ten-year period (1951-56 and 1956-61) showed that there was a reduction in their standardized lung cancer rate during the time that lung cancer rates were rising in the male population of Great Britain. More recently, another report by Doll suggests that this trend is becoming more marked as the rate of smoking among British physicians continues to decline and the period of cessation of smoking increases.

ACTION:—Many physicians have taken action and stopped smoking cigarettes, but there remain more who owe themselves a penetrating review of the evidence.

Action requires education of, and support to the patient who wants to, or should be advised to cease smoking. Action requires support and involvement with the agencies and organizations endeavoring to give our youngsters all of the available information, and not just the "advertised glamour and adultness" of smoking before their "period of recruitment as new smokers."

Action also requires that all individual physicians; the MSMS, as the organized spokesman of Michigan physicians; and the AMA assume an active role in this vital issue through leadership and active participation in this campaign against the greatest man-made epidemic in medical history.

COMPREHENSIVE prevention of disease will be fundamental to the practice of medicine in the future. We have an opportunity to promote this by action in the present. ☐

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Doctors Are Needed On School Boards

BY H. J. HAZELDINE, M.D.
MEMBER, PORT HURON
BOARD OF EDUCATION

Because the medical profession is one of the most demanding of time and energy, doctors have intentionally avoided public service. I feel too, most doctors have used this as an excuse instead of a real reason to avoid civic participation. Some have felt that public participation on controversial affairs-such as political, federal, state, and local government-would harm his practice.

Despite all the negative reasoning, I feel a doctor has a special understanding to offer to community services and especially in the field of education. Due to his type of training in reasoning, he can make a great contribution to a board of education in analyzing and understanding the educational processes, needs and responsibilities to the people, students and educators. He can carry out a service to the board of education that few people can do. A doctor, because of the nature of his profession, has no personal axe to grind, therefore can function totally without business prejudices.

We must not forget that children are the most important natural resource of our country. It is important in this era of technology to understand that if we do not educate our children we will support them as drop-outs and as public liabilities.

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The Medical Profession and the Public: An Examination of Interrelationships

BY ODIN W. ANDERSON, Ph.D.
UNIVERSITY OF CHICAGO

Introduction

A characteristic of the medical profession is its tendency to feel misunderstood.

In the art and the science of medicine the medical profession is accorded a great deal of necessary autonomy, but in methods of organization, delivery, and payment for their services they are likely to be accorded less freedom to follow their own predilections. In this country, however, the profession has always had more freedom in this regard than in other countries.

The profession's very freedom to determine both the art and science of medicine and methods of delivery until the recent past, tends to make it feel beleaguered and misunderstood when social and political forces impinge on their accustomed way of delivering services. Indeed, this separation may not even be possible, hence the profession is placed in the uncomfortable position of defending the status quo and slow change in the name of the indissoluble link of freedom and quality while at the same time being accused of extreme economic self-interest while doing so.

In this country self-interest is regarded as one of the strongest motives for self-advancement, hence the profession is caught in the toils of an over-simplified reason for behaving as they do.

THE PROFESSION HAS always been on the defensive everywhere when exposed to innovations in methods of delivery and payment for services. External stimuli have forced internal changes in methods of delivery and payment. The medical profession had not accepted new methods of delivery and payment until pressures were so overwhelming that the untenable alternatives of some kind of accommodation or capitulation were forced.

I stress the organizational aspects of the delivery of service and differentiate these from the art and science of medicine. In the latter, medicine has led and innovated. As a profession it could, of course, do no less if it were to function as a private self-regulating profession in a liberal and pluralistic society. Since the revolutionary change in the art and science of medicine brought about by scientific research, the issue has always been joined between society and the profession on methods of delivery and payment and not on the art and science of medicine.

The two segments are not mutually exclusive, they are interrelated. This, I believe, is the basis for the heated controversies regarding third-party payments, group practice, government intervention and the medical profession. The profession has exaggerated the intrinsic values of methods of delivery and payment to which they have been accustomed; the proponents of change have underrated the impact of new methods of delivery and payment on the traditional structure of medical practice, assuming that the change is merely one of source of payment.

THESE OBSERVATIONS ARE statements of fact and it would seem plausible interpretation, and as such are not meant as praise or blame. I assume it to be a truism that all human behavior takes place in some kind of social context of reciprocal relationships, that all behavior has intended and unintended consequences.

It is in this spirit I hope to examine the interrelationships between the medical profession and society from the latter Nineteenth Century to the present time with some glimpse into the future. I assume that self-knowledge is better than none, and that knowledge will result in more intelligent debates as to the issues and better articulated compromises between groups at interest than if sparring for position takes place in an atmosphere of mutual ignorance, misplaced pride, and recrimination.

If I cannot make this assumption then, indeed, the democratic process and rational social institutions based on knowledge and intelligent accommodations are impossible.

The Origin of the Current Structure Of Personal Health Services

Before medical practice was transformed by the medical scientific revolution at the turn of the century, physicians were engaged in private practice for fees from patients who sought their services. Physicians maintained their own offices. There were roughly as many, if not more, physicians in practice then in relation to population as there are now. Medical practice was part and parcel of a society in which private and individual enterprise was encouraged as the chief means of delivering and producing the goods and services that people desired.

The role of government was to maintain order, administer justice, assure a salubrious physical environment, defend the country against external enemies, facilitate interstate and international commerce, and provide in some way for the poor. There were, of course, exceptions but the latter Nineteenth Century in the United States represents as pure a laissez-faire concept of government and economy as has existed anywhere.

IN THIS CONTEXT A RAPIDLY expanding middle and upper income class and a relatively small poverty class were able to provide a source of livelihood for many medical practitioners. Hence, solo private practice, fee-for-service, and free choice of physician became characteristics of medical practice in Western Europe, Great Britain, Canada, and other Commonwealth countries, but particularly in the United States. This country was able to support a relatively large and viable private practice system.

Antisepsis and anesthesia were two specific medical factors influencing the growth and development of the general hospital during the latter part of the Nineteenth Century and into the Twentieth Century. Although surgical technique was already quite highly developed before the last quarter of the Nineteenth Century, large scale application was not possible because of the extremely high rates of postoperative infections, and the crude or nonexistent methods to alleviate pain. Antisepsis and anesthesia made the hospital and surgery both safe and relatively painless. A great many hospitals were capitalized by philanthropic and other private funds as gifts to the public welfare.

The result was the creation of the voluntary hospital system which to this day remains the backbone of hospital care in this country. The voluntary and general hospital became community-oriented hospitals immediately, serving both charity and private pay patients. In the main, separate hospitals for charity patients and private patients did not become an American pattern. The voluntary hospitals received the bulk of their income from pay patients. Some of this income was used to subsidize charity patients, and the rest

Among the Predictions by Professor Anderson:

"The balancing of professional prerogatives and patients' financial prerogatives will be the predominant concern of public policy regarding medical care for some time to come."

"Insurance benefits must be improved and such improvements will bring all physicians more and more into the orbit of third-party payments."

"An increasingly higher proportion of physicians' income will come from insurance agencies and government, but particularly insurance."

"Physicians will face increasing pressures to standardize their fee schedules and establish visible top limits."

"The trend toward salaried positions and group practice will continue."

"There will be an increase in the number of full-time hospital chiefs-of-staff."

"There will continue to be increasing interest in some form of utilization control mechanism in hospitals."

"Pressures on the medical profession will persist."

of the income for such patients came from philanthropy and government.

AT FIRST, THE GENERAL hospital was primarily a facility for surgical patients. The hospital made arrangements with surgeons to admit their private patients. The hospital charged the patient for a daily rate for room (American plan), general nursing, and ancillary services such as the operating room. The surgeon charged the patient directly for his services. Hospital admission privileges were much sought after by surgeons as a place to improve their skills in connection with free services to charity patients. The surgeon maintained his own office outside of the hospital.

Eventually medical patients in increasing numbers were admitted to the hospital with the same arrangements between the physician and hospital. And still later maternity patients were admitted to hospitals in large numbers. Thus emerged the current and prevailing structure of hospital and physicians' services, physicians remaining as autonomous practitioners with co-equal status among those who had hospital practice privileges.

The fee-for-service method of payment continued as the prevailing and almost exclusive method, and physicians remained autonomous individual practitioners largely in individual offices.

IT IS THUS SEEN that the structure of hospital and medical practice grew up spontaneously within the conditions present in the United States at the turn of the Century, and the adjustments and accommodations that seemed to be quite natural. The prevailing philosophy of the role of government and inherent in that philosophy the great reluctance to levy taxes gave the private and nonprofit sectors an area to develop and expand as seemed quite natural within the American context of the period.

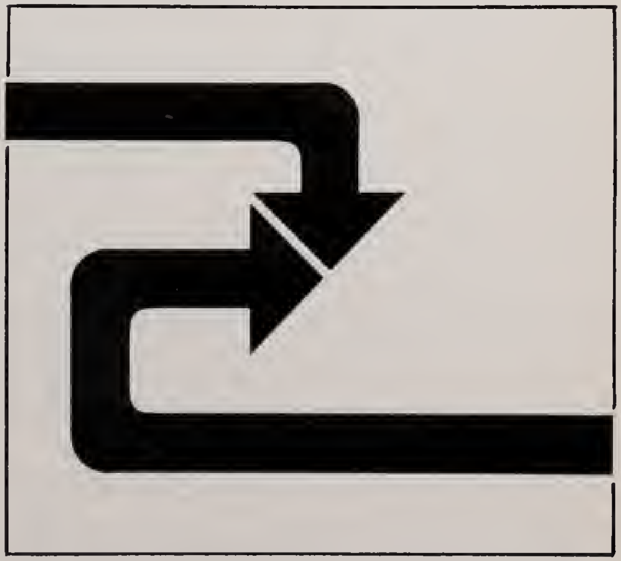
The medical scientific development alluded to previously was absorbed gradually but steadily into the medical practice structure once the medical schools became associated with the universities after the Flexner report released in 1910. This report was sponsored by the Council of Medical Education of the American Medical Association.

Further, the state licensing boards agreed to license only the physicians who were graduates of medical schools accredited by the American Medical Association. Thus, the new knowledge and the graduates of the improved and remaining medical schools (reduced from 160 to 80 between 1910 and 1915) were fed into the existing hospital and private medical practice structure. The medical profession accepted innovations in medical knowledge and technology rapidly. The hospital and medical structure described remained intact, and by 1920 the structure as it is now known reached its full development. Additions since this period have been refinements and filling out of the structure as it appeared around 1920.

Between 1915 and 1920 an innovation in the source of financing was supported in 16 states, by middle class and educated social reformers who had been active in promoting workmen's compensation, child labor laws, improved working conditions, public health programs for mothers and infants and related reforms.

There was agitation for some form of government-sponsored and supported health insurance plan for the entire population in order to assist workers and their families in paying for the hospital and physicians' services. The imposing hospital and physician services' edifice had been raised, and it was now realized that it was difficult for families to pay for these services as needed and used. The American Medical Association and state medical societies in the states concerned, the insurance industry, and other business groups opposed these reforms.

Further, organized labor was apathetic and by 1920 this particular innovation in financing health



services, copied from Germany and Great Britain, got nowhere. In 1920 the American Medical Association passed a resolution proscribing all forms of government support for health services except traditional public health programs, services for the indigent, and special groups like Veterans. It is not coincidental that the AMA by 1920 had over one-half of the physicians in the country as members.

THE SECOND ATTEMPT at innovation in financing of hospital and physicians' services took place in the Thirties, starting with insurance covering hospital care and sponsored mainly by the hospitals and hospital associations, and later for physicians' services sponsored by the state and local medical societies. The medical profession preferred a "wait and see" policy regarding the hospital insurance plans fearing that the hospital prepayment plans might be insolvent, and being quite skeptical of an enterprise not controlled by medical professionals. Latent was the constant uneasiness regarding the ever-present possibility of third-party interference with medical practice.

In the latter Thirties, medical societies from coast to coast sponsored and organized medical prepayment plans to help families pay for physicians' services mainly in the hospital. These were stimulated by the successful operation and expansion of the hospital plans, but particularly by the impetus given by the passage of the Social Security Act in 1936 to some form of federal-state health insurance system embodied in the series of Wagner-Murray-Dingell bills introduced in Congress from 1939 on.

THE MEDICAL PROFESSION was able to accept innovations in the science of medicine readily, but was not willing to accept innovations in methods of paying for physicians' services. Hence, voluntary health insurance has been a defensive action on the part of the profession, and hence, also, aggressive leadership has been lacking. Private insurance companies, in a sense, and very likely much to the relief of the profession filled the slack left by physician-sponsored medical plans and became an important complement to medically-sponsored plans.

Concurrently, another innovation concerned the organization rather than the financing of physicians' services. The organized medical profession expressed little enthusiasm for the principle of group practice preferring the individual physician, fee-for-service structure that had evolved during the latter Nineteenth Century and solidifying in the Twentieth.

The issue was joined, however, when in the latter Thirties and Forties several medical groups were established with prepayment added. Rather bitter court fights took place in which the medical profession was accused of restraint of trade because group practice physicians were unable to acquire hospital privileges in community general hospitals. There were also internecine battles generally. These organizational innovations were sponsored by physicians, interested laymen, and consumer organizations but these physicians were deviants from the mainstream of the medical profession in their concept of methods to deliver services.

IT IS NOT MY INTENTION to imply that the initial opposition to the financing and organizational innovations were carried out in bad faith. I simply assume that the opposition and reluctance to change were based on the profession's perception of what it felt was in the best interest of the patient and medical practice. I take their reasons at face value. Their subsequent accommodations to methods of financing and to some degree methods of organization are a matter of record.

What I do find impressive bordering on the awesome is the tenacity with which the profession holds to the time honored values of autonomous and individual practice and fee-for-service method of payment.

I cannot write off these deeply-held values as being whimsical or selfish although methods used to stall innovations may have been ill-advised. All professions entertain certain methods and contexts in which to function according to its most deeply held intuitive feelings. In any case, the medical profession has succeeded in maintaining the essential features of the traditional structure of medical practice intact, and insurance agencies have had to accommodate this structure as much as medical practice has had to accommodate to them.

During the last 30 years the health services structure has absorbed a tremendous increase in use of hospital and physicians' services, hospital and physicians' use have doubled. The expenditures for these services and the expenditures for capital financing of both hospital facilities and physicians' offices have tripled and quadrupled. Clearly health services have been increasingly desired by the American people. By all standards, health services is a growth industry which is absorbing a larger portion of family income and gross national product.

Polar Models Of Delivering Physicians' Services

A common method of sociological analysis is to set up models which do not actually exist in their pure form, but which appear to lurk in the background as concepts and are used as reference points by proponents and opponents. In medical practice the two polar models in this country are so-called solo and individual practice and so-called group practice.

THE MODEL OF MEDICAL practice regarded as ideal by the great bulk of physicians in practice is the solo and autonomous physician in his own individual office, competing for patients on the basis of service (only to a minor degree on the basis of price), paid fees for each service directly by the patient as set by the physician.

Patients have free choice of physicians, and physicians can pick and choose patients in regard to their specialties, serving any patient who selects them and complies with their instructions regardless of race or creed, or income. Physicians attract clientele who provide a base of demand and income, and they establish a network of relationships with hospitals and other physicians in order to refer patients to the great range of specialties and facilities in modern medical practice. The physician is, of course, licensed by the state and is subject to liability laws regarding professional services.

The physician is a completely, free-standing and autonomous practitioner who determines his level of quality, volume of practice, and the nature of his fees. All this takes place, of course, within a range of community patterns and norms which are probably felt more than made explicit.

No third party in any direct sense involves itself with the physician and the patient. The physician prefers not to have a contractual arrangement with an insurance agency. His contractual arrangement is solely with the patient. This is the reason, it seems to me, why physicians were initially reluctant to endorse some form of insurance to assist patients in paying for physicians' services when medical costs are incurred.

THE IDEAL WORLD for the physician is an absence of third-party payors which seems to intrude itself in both quality and fiduciary relationships between the physician and the patient. Obviously, this kind of a model is loaded on the side of the physician, because as has been shown repeatedly, the patients' needs for services vary considerably from year to year and sometimes upset seriously the family budget; hence insurance, and the adjustments this model of medical practice has had to make.

It seems that the medical practitioner does not differentiate between methods and amounts of payment on the one hand and professional prerogatives to diagnose and prescribe as he sees fit on the other. The practitioner seems to regard

AUTHOR

Doctor Anderson is Professor and Research Director, Center for Health Administration Studies, Graduate School of Business, The University of Chicago.

both of these as fundamental and interrelated prerogatives of professional freedom.

The other polar type is a group of physicians of sufficient number and variety of specialists to provide the full range of modern physicians' services from one center and also closely affiliated with a hospital. Further, such group is associated with an insurance plan which through a pooling of funds pays for all physicians' services; there is no charge at all to the patient at time of service.

Physicians are on a salary and one of the assumed advantages of this arrangement is that physicians can divorce costs from service, and hence prescribe what they feel is best for the patient regardless of cost in a particular instance. The patient selects the group and not a physician in the group, and therefore, relates himself to the institution. This does not preclude continuous relationships between some physicians and patients, but I am describing the logical end result of this type of system.

The physicians in a group have a great deal of the medical armamentaria on the spot; the solo practitioners refer to other physicians and medical equipment in the community at large. It is obvious that the solo-practice system is highly structured. The solo practice system tends to be patient oriented rather than peer oriented, and the group practice system the reverse. This patient orientation is in regard to patient convenience and wishes rather than to quality of care. The solo practice system is more manipulable by patients, but the group practice structure is easier for patients to use once they are in the system. This is admittedly a very brief description of a very complex subject.

Prevailing Range of Alternatives

It is quite literally possible today for a physician to engage in a type of practice ranging between the polar types described in the previous section.

Many kinds of combinations are possible. A physician can be engaged in solo practice and have an appointment as a part-time school physician or as a physician in an industry. A physician can be based part-time in a group practice prepayment type of structure and be a solo practitioner with his own office as well. A physician can be a member of a group and be paid according to his volume of work or be paid a salary. He can be on the faculty of a medical school and also be in private practice.

The combinations are quite endless. It is also clear that a physician can be paid by a variety of methods from fee-per-service to a salary. Some alternatives are easier to enter than others because of varying opportunities as seen in the distribution of types of practice.

THE FREQUENTLY OBSERVED changes in medical practice have been stupendous during the last 35 years; specialization has proliferated, source

Among the Observations by Anderson:

"It seems that the medical practitioner does not differentiate between methods and amounts of payments on one hand and professional prerogatives to diagnose and prescribe as he sees fit on the other."

"There seems to be a pervasive uneasiness, bordering on fear, with the gradual shifting of the source of payment from the patient to a third party."

"Review of practice in physicians' offices still seems remote since a great deal of medical practice necessarily takes place in private."

"I am quite skeptical of the ability of utilization review committees to control use effectively and equitably given current knowledge or even near-future knowledge."

"No other profession has as many alternatives open to it as does the medical profession to practice in a wide range of settings."

of payment from the patient to some type of third party has shifted greatly; the types of settings in which physicians serve have increased. Withal, however, it would seem that the structure of private practice which had been developed by 1920 still remains essentially intact. About two-thirds of physicians are in private practice (86% in 1931). More and more physicians are occupying research, teaching, and administrative positions, and may have extended their graduate training in residencies.

The main shift with the greatest implication for private practice, however, has been the source of payment occasioned by the rise of voluntary health insurance. The solo-practice fee-for-service method of payment still remains the dominant model of practice as measured by volume of patient care. The insurance mechanism has been grafted to this structure of practice. Important exceptions are the group practice prepayment plans, but so far they cover only about five per cent of the population. Their growth continues, but it is slow.

There is also a continuing growth in group practice units but best estimates currently would be that around 10 per cent of practitioners in this country are members of these units.

TODAY OVER 25 percent of physicians' incomes in private practice come from voluntary health insurance. The percentage varies considerably among physicians. Among surgeons it is almost two-thirds. General practitioners and internists earn very little from insurance, because insurance for physician services is designed mainly to cover in-hospital physician services. This is changing somewhat because of the gradual increase in the percent of the population covered by major medical type of insurance. Physicians' incomes in this system are by all standards very good — the net is now $26,000 a year or so — although the working hours are very long and the patient load heavy.

It should, thus, be clear that the current system gives the physician a tremendous range of alternatives and combinations of alternatives, as it also does for the patient who knows how to use the system.

It is, therefore, ridiculous to classify medical practice into solo and group practice, because they hardly exist in their pure form. Solo practice is mainly an economic concept in that the physician sets and collects his own fees from patients he cares for. Solo practitioners engage in a great deal of informal group practice by shared office resources and by referrals to other physicians, and can maintain a high degree of fluidity in how he calls on the facilities and other physicians in the community. Group practice is a formalized method of referrals within the same group.

In either case, however, no studies have been done showing how physicians refer to each other in the handling of cases. No studies have been made of a cross-section of practices and a typology of practices established.

A FINAL AND A summary observation is that physicians may be bewildered at the proliferation of practice sites and types open to them, but more deeply there seems to be a pervasive uneasiness, bordering on fear, with the gradual shifting of the source of payment from the patient to a third party.

There seems to be fear that third-party payments will erode the fee-for-service method of payment as it was known before insurance and that physicians will lose control as individuals over the amount of fees, and possibly, even lose some autonomy over their prerogatives of diagnosing and prescribing as they see fit.

THESE FEARS ARE NOT baseless, although they may be exaggerated. External conditions should, however, encourage physicians to re-evaluate what is meant by professional freedom in relation to the family's need for some method of paying for physician's service as it does for paying for other contingencies.

So far, it seems that physicians have really not understood the patient's financial problems (as distinct, of course, from his medical problems). I do not mean that physicians are not sympathetic with a patient's financial problems and would be willing to lower fees, stretch out the payment period, and so on. It seems, rather, that physicians still have difficulties in seeing medical costs as contingencies that occur more or less randomly in a population. They seem to prefer to assume full responsibility for how a patient pays for his care on a person-to-person basis.

The public resents being beholden to anyone, and prefers to pay their way. For medical services, insurance is the accepted method of paying for services.

THE BALANCING OF professional prerogatives and patient's financial prerogatives will be the predominant concern of public policy regarding medical care for some time to come. Up to now, the providers of service have determined their own destiny according to their own predilections and wisdom in a free-wheeling economy.

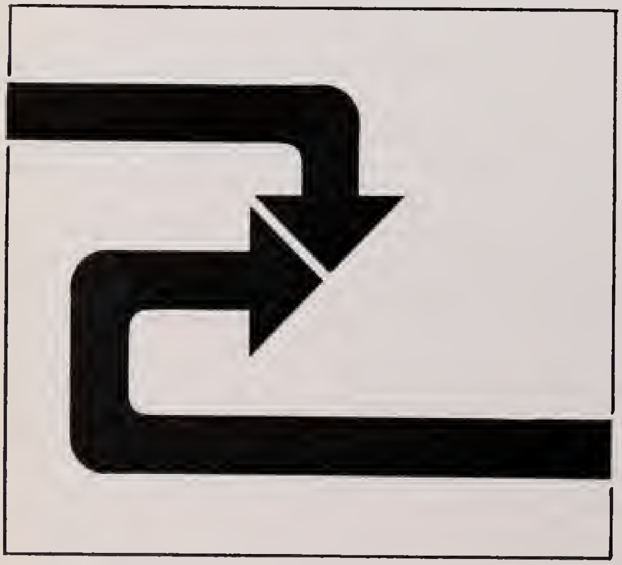
A health services establishment as measured by quality and quantity of facilities, medical educational institutions, physicians' offices, has emerged second to none in the world despite all obvious deficiencies.

A serious deficiency remains although it is gradually diminishing — the insurance benefits must be improved and such improvements will bring all physicians more and more into the orbit of third-party payments.

A subsidiary issue in my opinion, although given high priority by many others, is the reorganization of medical practice into some form of group practice.

How structured medical practice should be is a question discussed and debated at length.

By and large physicians are reluctant to enter into highly-structured practice situations. Again the issue is not clear cut solo-practice or group practice. It would seem that various measures can be taken to establish criteria of performance and standards for so-called solo practice acceptable to the profession generally. In passing, it can also be said that such criteria are not concrete for group practice situations either.



Future of Medical Practice

It would seem to be a reasonably sound prediction that general practitioners will continue to decline in proportion to all practitioners, if I define general practice as general physician care for the individual or family excluding obstetrics, pediatrics, surgery, and eye, ear, nose, and throat and all other specialties.

The question remains as to how small a proportion of all physicians will be comprised of general practitioners. One of the factors which will help to determine the proportion of general practitioners is the extent to which they will have hospital admisson privileges.

ANOTHER PREDICTION is that an increasingly higher proportion of physicians' incomes will come from insurance agencies and government, but particularly insurance. So far over one-half of physicians' incomes on an average are paid directly by the patient. Clearly, the family needs to have this portion reduced considerably, so that eventually possibly 80 percent or more of physicians' charges are paid by insurance.

Following from the foregoing, physicians will face increasing pressures to standardize their fee schedules and establish visible top limits. It is not reasonable for physicians to assume that when insurance and government guarantees payment physicians individually can charge variable fees as they see fit. The fee system of charging developed in a context of no nsurance. Large buyers require some guarantees of stable fees over periods of time. I do not suggest that insurance needs to pay 100 percent of fees; I am suggesting that whatever proportion insurance pays, the proportion the patient may be charged in addition should be a predictable one.

THE TREND TOWARD salaried positions and group practice will continue.

It is unlikely the pace will be as great as proponents predict and hope, or that even the majority of physicians in full-time practice will be so engaged. I cannot but be impressed by the apparent reluctance of physicians to practice in highly structured situations — excluding places like Mayo, teaching centers and so on — or of private patients to use clinic type facilities. As long as physicians continue to have the range of choice of sites, I would predict that the majority of physicians will continue to practice in individual offices or in small, flexible partnership units which can appear and disappear as partners see fit.

In line with the foregoing, I would suppose there will be an increase in the number of full-time chiefs-of-staff in hospitals, but other physicians will be affiliated more or less as they are now.

I frankly cannot predict, as so many do, that the hospital will be the center for *most* of the medical care in a community as long as physicians have the option of having offices, separate from the hospital although perhaps increasingly contiguous to or near the hospital. Although the hospital can muster greater technical resources and more control than a single physician or a small group of physicians, I would predict that physicians will counter the trend toward the hospital by providing their own offices with diagnostic and treatment equipment not necessarily associated with surgery. Physicians have the gross incomes and borrowing ability to invest in equipment which will not be as heavily used as it might be in the hospital. The economy will continue to be flush enough to tolerate this "waste" of resources or consumers with money will demand if service is more personal.

There will continue to be increasing interest in some form of utilization control mechanism in hospitals. Physician practice in hospitals will be scrutinized as to length of stay, procedures recommended, and perhaps, also, at time of admission. Review of practice in physicians' offices still seems remote since a great deal of medical practice necessarily takes place in private. Record keeping systems have to be exceedingly detailed to monitor what takes place in office practice.

I am quite skeptical of the ability of utilization review committees to control use effectively and equitably given current knowledge or even near-future knowledge. Nevertheless, review methods will likely be able to go so far before the profession reacts. The profession will continue to be very powerful in matters touching traditional professional prerogatives.

IN SUMMARY, THEN, it would appear to me that no other profession has as many alternatives open to it as does the medical profession to practice in a wide range of settings. They will continue to be in relatively short supply and high demand indefinitely, and therefore, will enjoy good incomes. They will have to make increasing accommodations in their fee-charging practices.

The American health services system will continue to be a loosely structured, fluid system for some time to come. Within this system physicians will have room to practice according to their preferences and predilections and consumer choices.

This guarded optimism, from the standpoint of the medical profession, should be tempered with the warning that pressures on the profession will persist. Accordingly, the profession will continue to feel misunderstood and even maligned at the same time that their services are increasingly effective and sought after.

Considering the options in methods of practice and promise of high incomes, it would seem that the profession will continue to enjoy a very tolerable way of life.

This article is the third in a series of original papers commissioned by the MSMS Committee on Medical Socio-Economics, Dale L. Kessler, M.D., Grand Rapids, chairman. The others were "The Outlook for Group Practice-Payment, Direct Service Plans during the Next 20 Years" by Caldwell B. Esselstyn, M.D.; and "The Future of Health Insurance, Prepayment and Medicine" by Charles P. Hall, Jr. The article by Temple University Professor Hall was later judged by the National Blue Shield organization as the most scholarly article printed in any medical publication during 1967 about socio-economic issues.

The Publication Committee welcomes comments on this third article.

Tuberculosis and Health Examinations Prior to Attendance at a Private Camp

ABSTRACT: Review of the health records of children at a private camp indicate a high degree of compliance with recent Michigan legislation regarding tuberculin testing of campers. Testing of camp personnel was less satisfactory. Further parent and physician education is necessary.

BY ROBERT A. GREEN, M.D.
ANN ARBOR

Michigan Act No. 169 of the Public Acts of 1966 indicates that persons in charge of a children's camp shall have on file a statement signed by a licensed physician that each child has been immunized against the usual childhood diseases and tuberculin tested (or possibly x-rayed) as well. The tuberculosis examination should have been performed within the preceding 90 days. It is understood that the licensing section of the Michigan Department of Social Services requires camp personnel to meet similar regulations.

Camp officers thus have a clear responsibility to ask the parents of prospective campers to arrange with their physicians that these requirements be met prior to the start of camp. I had the opportunity to be camp physician at a private camp in northern Michigan primarily for Michigan residents of high socio-economic status during the summer of 1967, and was able to review the success of this venture into preventive medicine at this single camp.

Standardized health forms prepared by the American Camping Association were mailed to parents of all applicant campers. A line was added by the directors of the camp requesting information about the tuberculin test. The parents had two responsibilities: to fill out the campers' medical history and to sign an emergency operative permission statement. The examining physicians had three responsibilities: to record the physical examination, to record the immunization history and to indicate if a tuberculin skin test had been done. Similar forms were sent to the camp staff.

Result

Camp records indicated that 252 children had been at camp during the summer. Review of their health forms suggests that parents could have been considered delinquent in their responsibility towards their own children's health in 77 (35%) instances. No health record at all was on file for 20; no medical history was given in 34 and an incomplete history in 11; and the operative permission was not signed for 12, even after a second request to do so was made after camp began. In addition to the 232 identified records, four health forms were found which were completed but had no child's name on them. Of these one child was noted to be allergic to penicillin and another to sulfa.

The examining physician had completed the physical examination form in all 232 instances, and a good immunization history was given in 227, truly an excellent record. The experience with tuberculosis control was poorer although still good (see table). Tuberculin skin tests had been done, one way or another, in 203 (80%), although a minority of these were within the three month period prior to the start of camp. It is of interest that of the 29 children in whom tuberculin skin tests had not been done six had physicians for

AUTHOR

Doctor Green is assistant dean of the University of Michigan Medical School.

TUBERCULIN SKIN TESTING OF 252 CAMPERS

No Health Record	20
No Tuberculin Test	29
Tuberculin Positive (On INH)	1
Known Tuberculin Negative (1966 or 1967)	89
Tuberculin Done, Presumed Negative	104
Tuberculin Done Prior to 1966	9

fathers, and of these six one father had taken an x-ray instead on his ten-year-old, one had performed tuberculins on other campers for whom he was the physician although not on his own child, and one child was a severe juvenile diabetic.

The experience with the staff of 93 was less satisfactory. No health form was available for 29. Only 43 were known to have had a tuberculin skin test done; one of these was positive, had not been recently x-rayed and was not on isoniazid.

A second provision of the law required the camp management to make available or report to the local health department the record of the immunizations and the tuberculin tests. The camp directors at our camp, and others with whom I spoke, were unaware of this provision, although clearly informed of and cooperating with the tuberculin requirements. No request for such a report was received from the health department.

Comment

I believe the requirement for tuberculin testing of campers is a well-conceived public health measure. Camp personnel should certainly be included, as are school personnel in a similar law, as the danger to children is greater from adults, who have a higher incidence of tuberculin positivity, than it is from other campers. The health department should make some provision for the reporting of the results of the tests if such is actually deemed necessary.

Lastly, further parent and physician education is needed if still better control is to be achieved.☐

Book Review

THE HUMAN ADRENAL CORTEX: ITS FUNCTION THROUGHOUT LIFE. (Ciba Foundation Study Group No. 27) Edited by G. E. W. Wolstenholme and Ruth Porter. 146 pp, Illustrated. Little, Brown and Company, Boston, 1967.

This is a brief volume of papers presented at a symposium in September, 1966. A much larger and more comprehensive volume on the same subject was published a number of years ago and the present one primarily reports advances in the last few years. These advances have been considerable although each author takes some pains to identify the still unanswered problems that are present. A list of those who presented papers and discussed them is quite impressive although one notices the absence of a few outstanding workers in the field, particularly those from the United States.

The material is presented largely in a chronologic fashion starting off with the function of the fetal adrenal and progressing to a paper entitled, "The Function of the Adrenal Cortex in Old Age." In addition, there is a discussion of the role of the adrenal cortex in pregnancy and presentations with regard to both acute and chronic stress. Although a few of the papers are of quite technical nature, the majority of material is quite easily read and should prove of considerable interest to anyone in medicine.

Among the discussions the reviewer found most interesting were those related to the function of the hypothalamus as the origin of pituitary stimulus and the use of the anencephalic monster to resolve some of the problems. It would appear from the work presented that the adrenal cortex is not essential for fetal survival. The newborn infant appears to be capable of producing very adequate amounts of the corticosteroids and the quantities found in the circulation are actually higher than later in life. One of the apparent reasons for this is because of an inability of the neonatal liver to metabolize these substances. The role of the adrenal in pubertal development is discussed.

An extremely interesting chapter discusses the interrelationship of the fetal adrenal, the placenta and the maternal organism. The synthesis of some of the estrogens, particularly estriol, is outlined and its measurement as a means of prognosticating pregnancy is presented.

The material on the response of the adrenal cortex to stress is well summarized but little really new material or new concepts are evident. It would appear from this review that the adrenal cortex remains responsive to stimulus well into old age.

As with other volumes from the Ciba Foundation, this one is very well edited anl physically is quite attractive. The diagrams and charts are well reproduced.

George H. Lowrey, M.D.
Scientific Editor

Teflurane: A New Halogenated Gaseous Anesthetic — First Clinical Experience

EDITORIAL COMMENT: Search for the perfect anesthetic continues. The authors describe a new gas-type of anesthesia with many desirable attributes but also a disturbing tendency to induce cardiac arrhythmias of a transient nature. (Scientific Editor George H. Lowrey, M.D.)

BY KENNETH LEVIN, M.D.
GUENTER CORSSEN, M.D.
BOTH OF ANN ARBOR

In the continuing search for a non-flammable anesthetic gas with intermediate potency, a compound with the formula 1,1,1,2-tetrafluoro-2-bromoethane (teflurane) has recently been explored.[1] Teflurane belongs to the series of halogenated hydrocarbons (Fig. 1) of which halothane (Fluothane) and methoxyflurane (Penthrane) have attained wide approval as effective and safe anesthetic agents. Initial reports suggested that teflurane may offer some distinct advantages over other halogenated anesthetics.

Teflurane is a gas which eliminates the need for the vaporizers used with volatile anesthetic agents. Because of its low water solubility the onset of anesthesia is rapid, and emergence from anesthesia is equally fast. In addition, the gas has a pleasant odor and is not irritating to the mucous membranes of the upper respiratory tract, ensuring smooth induction of anesthesia. Also, cardiovascular and respiratory depression do not seem to pose any serious problem during light teflurane-induced surgical anesthesia.

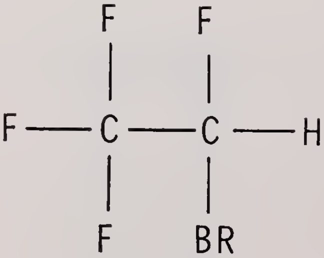


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Figure 1: Chemical Formula of Treflurane (Tetrafluoro Bromoethane)

Preliminary clinical exploration of teflurane was temporarily suspended when it was reported[2] that pathologic changes had occurred in kidney tubules of dogs anesthetized with teflurane for long periods. Further studies,[3] however, failed to confirm the findings of nephrotoxicity, and clinical studies with teflurane were resumed. A favorable account[4] of the use of this agent in approximately 150 patients seemed to confirm its suitability and usefulness in clinical anesthesia, and prompted us to initiate a clinical trial with teflurane in our institution.

Method

Teflurane was administered to 45 patients (20 male and 25 female) from 3 to 83 years old, who had been scheduled for elective surgical procedures. Table 1 lists the surgical procedures carried out under teflurane anesthesia. The length of operation ranged from ½ to 4 hours.

General surgery	23
Bone and joint	13
Genito-urinary	3
Neurosurgery	2
Ophthalmology	3
Otorhinolaryngology	1
Total	45

Table 1: Types of surgical procedures carried out under Teflurane anesthesia

Premedication consisted of atropine or scopolamine (0.1 to 0.4 mg) alone or in combination with pentobarbital (50 to 150 mg), depending on age and weight of the patient. The medication was administered intramuscularly, 30 to 60 minutes before induction of anesthesia. Five patients received in addition to this premedication, 1 to 2 ml. of droperidol given intramuscularly 60 minutes before surgery. In 7 patients the beta-adrenergic blocking agent propanolol (Inderal) was administered intravenously (1 to 2 mg) one minute before the start of anesthesia.

Blood pressure (inflatable cuff method), pulse, and respiration were checked before the start of anesthesia and every five minutes thereafter until the patient had awakened. The electrocardiogram (Lead II) was monitored continuously and recorded directly. For induction and maintenance of anesthesia, nitrous oxide-oxygen mixtures and teflurane were the only anesthetics used.

Induction of anesthesia was accomplished by administering 6 L/min. of nitrous oxide and 2 L/min. of oxygen by mask via a semi-closed, circle filter, carbon-dioxide absorption system. One to three minutes after the administration of nitrous oxide oxygen had begun, teflurane was added to the inhaled mixture at a flow rate of 100 ml/min. Every 30 seconds the rate was increased by 100 ml/min. until the flow of teflurane had reached 600 ml/min. with nitrous oxide and oxygen administration continuing at the initial rates. The nitrous oxide flow was then reduced to 3 L/min. and the flow of oxygen increased to 3 L/min. providing a 50:50 mixture of nitrous oxide-oxygen with 600 ml/min. of teflurane (10%). After administering this mixture of nitrous oxide-oxygen and teflurane for 1 minute, succinylcholine (60 mg) was given intravenously to facilitate the orotracheal intubation which was carried out in all patients. For maintenance of surgical anesthesia the administration of nitrous-oxide oxygen was continued at 3 L/min. each with teflurane added to this mixture at rates of 100 to 300 ml/min. In most cases the patient was allowed to breathe spontaneously with the respirations assisted; when muscle relaxants were used, the respirations were controlled.

Muscle relaxants during maintenance were used in 10 patients (9-d-tubocurarine, 1-gallamine) to provide adequate relaxation of abdominal muscles.

In 5 patients the cardiac output was determined (cardiogreen dilution method) before anesthesia (control), 5 to 10 minutes after endotracheal intubation when the patient appeared to have stabilized in surgical anesthesia, and immediately after the patient had awakened from anesthesia. At the same time, arterial PO_2, PCO_2, and pH were determined in 15 patients (radial or brachial artery).

In the early postoperative period patients were observed for recovery time. A patient was considered awake when he was responding to commands and was oriented as to person, time, and place. All patients were interviewed on either the evening of the operative day or the first postoperative day.

TEFLURANE

ARTERIAL PO_2, PCO_2 and pH

Pat: M.C., 85 year female, Removal Femoral Head (rt.)

	pH	PO_2 (mm/Hg)	PCO_2 (mm/Hg)
CONTROL	7.42	60	40
DURING SURGERY	7.47	200	38
POST OP.	7.42	80	42

Table 2: Arterial Po , Pco$_2$, and pH Before, during and after teflurane anesthesia

Results

With the exception of 6 patients, induction with teflurane was smooth and uneventful. As a rule, consciousness was lost one minute after teflurane had been added to the inhaled mixture at flow rates of 100 to 150 ml/min. Surgical anesthesia was established within 3 to 6 minutes with flow rates of teflurane ranging from 300 to 600 ml/min. There was no coughing, breath-holding, or evidence of upper airway obstruction. In all patients of this series an orotracheal tube was placed with the aid of intravenous succinylcholine.

Arterial blood gas analysis and pH determinations revealed values which ranged within physiologic limits indicating adequate respiratory exchange. A typical patient's record is shown in Table 2. It should again be pointed out that spontaneous and unassisted ventilation was not relied upon, but respirations were either assisted or controlled.

Muscle relaxation: Relaxation of the head and neck musculature appeared to occur early during induction. Abdominal muscles did not seem to relax adequately for carrying out intra-abdominal procedures unless muscle relaxants were employed.

Cardiovascular System: The cardiovascular system appeared stable, as reflected by the blood pressure values which did not significantly change during the course of anesthesia. In only 4 patients

(9%) a temporary fall in systolic and diastolic levels occurred. The pulse rate did not change significantly in 39 patients.

Cardiac arrhythmias of the ventricular and supraventricular type occurred in 32 patients. They were observed predomininantly in connection with orotracheal intubation but were also recorded during induction and maintenance of anesthesia and the recovery period. Figures 2, 3, 4, and 5 show the types of arrhythmia which were noted.

The occurrence of cardiac arrhythmias appeared to be related to the concentration of teflurane inhaled. At 10% teflurane, as used at the end of induction before the endotracheal tube was placed, cardiac arrhythmias occurred in 58% of the patients. Immediate reduction of teflurane to 5% or less resulted in spontaneous cessation of cardiac irregularities within 30 seconds to 3 minutes. However, in 7 patients (15%) arrhythmias persisted for 3 to 5 minutes despite the administration of oxygen with the flow of teflurane shut off.

There was no indication that the use of the alpha-adrenergic and antiarrhythmic agent droperidol given as preanesthetic medication influenced the occurrence of arrhythmias, since in all 5 patients in whom droperidol was used, cardiac irregularities were recorded. With the beta-adrenergic blocker propanolol, arrhythmias mostly of the supraventicular type occurred in 4 out of the 7 patients. Propanolol itself was not without hazard since it produced severe bradycardia in 3 patients and asystole of 6 seconds duration in 1 patient (see Fig. 6).

Surprisingly, the cardiac output determinations carried out in 5 patients revealed a reduction of cardiac output during surgical anesthesia in all five instances, the average decrease being 18.3% (Table 3).

CHANGES IN CARDIAC OUTPUT

Pt. #1.	(—) 14.8%
2.	(—) 18.2%
3.	(—) 12.3%
4.	(—) 30.5%
5.	(—) 15.7%
Average	(—) 18.3%

Table 3: Changes in cardiac output during teflurane anesthesia.

Emergence: Emergence from anesthesia was quick and smooth. Of the 45 patients, 40 awakened on the operating table 1 to 3 minutes after teflurane was discontinued, and the other 5 were awake within 5 to 10 minutes. Some of the patients appeared to be euphoric for a short time immediately after awakening. Nausea and retching occurred in 8 patients, of whom only 3 actually vomited.

Discussion

Teflurane is a potent and effective anesthetic agent. Surgical anesthesia is produced in concentrations ranging from 6 to 8 volumes percent combined with nitrous-oxide,oxygen. It appears that this non-explosive, non-flammable gas resembles cyclopropane in many aspects, except that the latter is explosive and flammable. Teflurane is non-irritating to the mucous membranes of the respiratory tract and is pleasant to inhale. Induction is smooth and rapid; excitement is rarely seen. Because of the drug's low water-solubility, saturation of the tissues is rapidly achieved and maintenance concentrations can be kept low. Overdose can occur quickly, however, because only

CO-AUTHORS

Doctors Levin and Corssen are both associated with the Department of Anesthesiology of the University of Michigan Medical School.

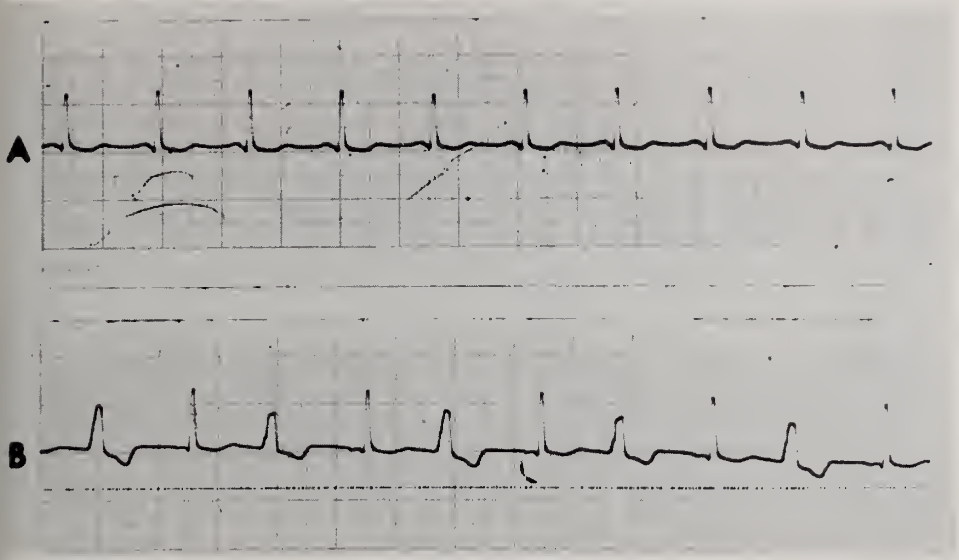

Figure 2: Pat. J. S. (#7), 53 year male; Op. Procedure: Incision and drainage of abscess R. Buttock. A. 9:30 a.m. — control, Pat. awake. B. 9:40 a.m. — induction with N_2O-O_2 (6:2 liter/min) - teflurane 400 ml/min. (Pat. in light surgical anesthesia). **Note:** Bigemini.

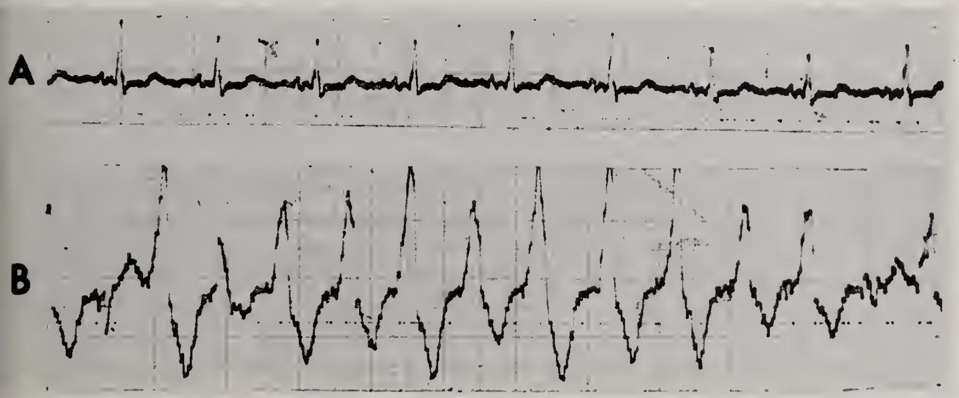

Figure 3: Pat. F. C. (#14), 51 year female; Op. Procedure: Excision of Clavicle. A. 10:29 a.m., control, Pat. awake. B. 10:36 a.m., placing endotracheal tube, N_2O-O_2 (3:3 L/min.), treflurane 600 ml/min. **Note:** Ventricular tachycardia.

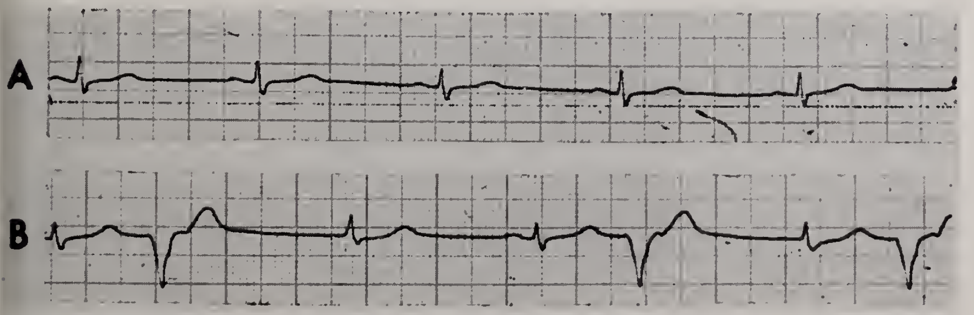

Figure 4: Pat. L. B. (#13), 57 year female; Op. Procedure: Retrogasserian Rhizotomy. A. 7:54 a.m. End of Induction, N_2O-O_2 (3:3 L/min.), Teflurane 600 ml/min. B. 8:20 a.m. Dissecting around Gasserian Ganglion, N_2O-O_2 3:3 L/min; teflurane 400 ml/min. **Note:** Premature ventricular contraction and Nodal rhythm.

small increases in the concentration of teflurane in the inspired mixture may lead to a rapid increase in the partial pressure of the gas in the tissues. Unlike cyclopropane, teflurane induces only minimal relaxation of muscles.

With the onset of surgical anesthesia, respiratory function appears to undergo a slight depression which increases with increasing depth of anesthesia. Therefore, spontaneous respirations should be mechanically assisted, and if muscle relaxants are required, the respiration should be controlled to avoid respiratory acidosis and anoxemia.

Emergence from anesthesia is usually rapid. The patient is immediately alert and oriented in less than 10 minutes after teflurane is discontinued. As with cyclopropane, patients emerging from teflurane anesthesia invariably complain of pain early in the postoperative period. Postoperative vomiting is rarely observed.

Artusio and his co-workers[1] suggested that the high incidence of arrhythmias observed in their early clinical exploration of teflurane may have been due to inaccurate metering of the gas through the cyclopropane flowmeter, with resultant unrecognized overdosage of the agent. In our own experience with a limited number of clinical cases, it has been apparent that even with accurate metering devices specifically designed for the administration of teflurane, the incidence and severity of arrhythmias have been significantly high. Antiarrhythmic medication did not significantly alter teflurane-induced cardiac irregularities. Neither the alpha-adrenergic blocking agent droperidol nor the beta-adrenergic blocking agent propanolol significantly influenced cardiac arrhythmias. There was some indication, however, that with propanolol, the arrhythmias tended to be supraventricular rather than ventricular. It should be pointed out that propanolol is a powerful myocardial depressant and its administration intravenously can result in severe bradycardia and even asystole, as described above.

Once arrhythmias occurred, regardless of whether the changes were recorded in connection with surgical stimulation or orotracheal intubation or were obviously the result of a higher concentration of teflurane, a reduction in the concentration of teflurane in a few instances resulted in immediate reversal and return to regular cardiac activity; often, however, the arrhythmia persisted for several minutes before sinus rhythm was resumed.

The fact that teflurane reduced the cardiac output strongly suggests that it is not a beta-adren-

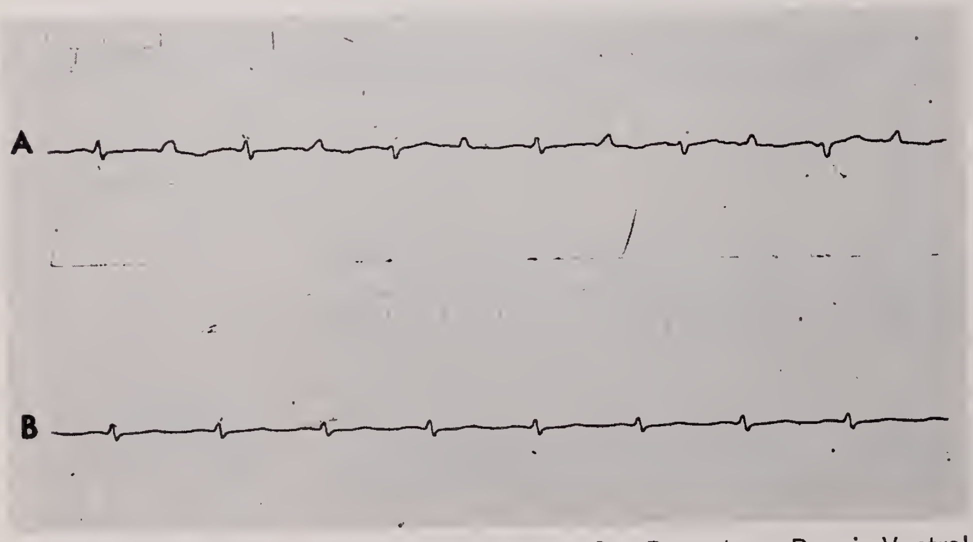

Figure 5: Pat. L. S. (#17), 56 year male; Op. Procedure: Repair Ventral Hernia. A. 3:30 p.m., maintenance with N_2O-O_2 (3:3 L/min), teflurane 300 ml/min. B. 3:50 p.m., surgery completed, N_2O-O_2 (3:3 L/min), teflurane off. **Note:** In spite of teflurane being discontinued, bigemini persist for 30 minutes.

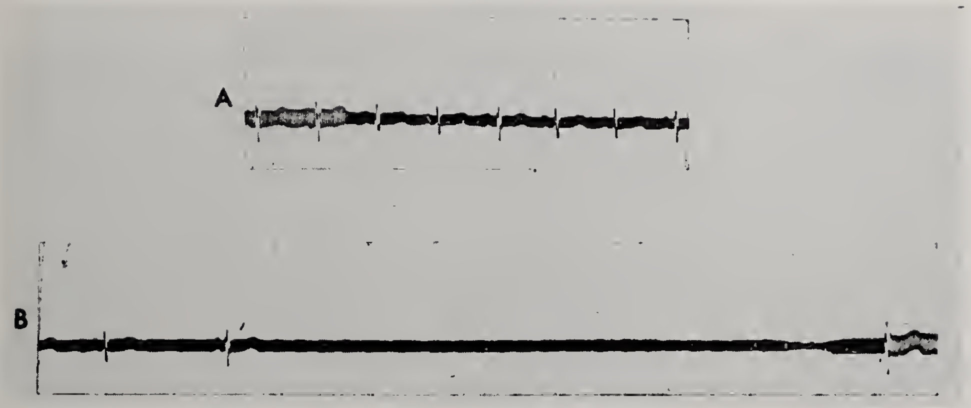

Figure 6: Pat. L. R. (#28), 4 year female; Op. Procedure: Tendon Graft. A. 11:45 a.m., induction with N_2O-O_2 (3:3 L/min), teflurane 500 ml/min. B. 11:51 a.m., induction; 4 minutes after propanolol (0.5 mg i.v.), N_2O-O_2 (3:3 L/min), teflurane 500 ml/min. **Note:** Asystole of 6 sec. duration.

ergic stimulant, which, in turn, may also explain why the beta-adrenergic blocking agent, propanolol, proved only partially successful in controlling or surpressing ventricular arrhythmias.

In conclusion it may be stated that teflurane is a potent anesthetic gas offering certain distinct advantages over some other conventional general anesthetics, including non-explosiveness, fast onset of action, rapid recovery, pleasant odor, circulatory stability, and minimal postoperative vomiting. The only significant disadvantage and potential danger in the clinical use of the gas is its arrhythmogenic property. Arrhythmias induced by teflurane cannot safely be suppressed by the use of potent antiarrhythmic drugs. Multifocal ventricular arrhythmias may occur not only with relative overdose of the agent but in concentrations of teflurane used for maintenance of surgical anesthesia.

Other means for effectively controlling teflurane-induced cardiac arrhythmias should be explored until this otherwise promising new halogenated anesthetic gas can be safely recommended for clinical use. ☐

Acknowledgement

The authors wish to thank Norman C. Wheeler, M.D., Abbott Laboratories, for supplying Teflurane and for his help and advice throughout the study.

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Intermittent Corticosteroid Treatment Of Demyelinating Diseases in Childhood

BY D. B. BASU, M.D.
JOHN GILROY, M.D., F.R.C.P.(C.)
JOHN STIRLING MEYER, M.D.
ALL OF DETROIT

ABSTRACT: There is evidence that both ACTH and corticosteroids are effective in the treatment of a number of demyelinating diseases including multiple sclerosis. Treatment is often limited by the development of serious side effects. The use of methyl prednisolone or prednisone in a single oral dose once every 48 hours reduces side effects and permits long term administration of high doses if necessary.

It has been shown that the immunologic activity of both the reticuloendothelial system and of the central nervous system may be suppressed by treatment with Adrenocorticotrophic hormone (ACTH) or corticosteroids in experimental allergic encephalomyelitis.[1,2] Similar immunological mechanisms may be involved in demyelinating diseases in man. It was therefore postulated that ACTH or corticosteroids may benefit these conditions.

There have been a number of favorable reports on the use of ACTH and Cortisone derivatives in the treatment of some demyelinating diseases in man. Alexander et al.,[3,4] were the first to show a statistically significant degree of improvement in subjects with multiple sclerosis treated with high doses of ACTH (100 to 120 units daily for 10-20 days, then decreasing by 20 units every 2 to 5 days) when compared with an untreated group acting as controls. There seemed to be greater improvement in those showing maximal adrenal response to ACTH stimulation as measured by high urinary 17-Hydroxycorticoid levels. Serious side effects such as gastrointestinal bleeding, edema, infection, osteoporosis and electrolyte disturbances were encountered in many cases and present serious limitations to this type of therapy.

Glaser and Merritt, and Merritt, et al, also reported benefit from ACTH and cortisone in treatment of multiple sclerosis, particularly in reduction of spasticity, ataxia and impaired bladder function. ACTH was administered three or four times daily but frequent side effects were reported. In England, Miller and Gibbons,[5] reported improvement in some cases of acute disseminated encephalomyelitis treated with ACTH as early as 1953, and since then Miller, et al,[6] have reported favorably on the use of both ACTH and Prednisolone in the treatment of multiple sclerosis.

The purpose of this paper is to report beneficial results of treatment of two forms of demyelinating disease that affect children resulting in a fatal issue or serious neurological deficits. The disorders were post-infectious leukoencephalitis and Schilder's disease and the treatment consisted of high doses of corticosteroids given intermittently. Certain advantages of intermittent therapy with corticosteroids compared to the traditional divided daily administration of these preparations will be discussed.

Reports of Cases Treated

CASE I: A 10-year-old white female was admitted to Harper Hospital on December 4, 1964, with recurrent vomiting, expressive aphasia and paralysis of the right arm of three weeks' duration. The illness began with a febrile episode lasting 5 days, approximately one month prior to admission. There was no history of allergy to drugs or any other acute illnesses. The general physical examination was within normal limits.

Neurological Examination: She was oriented to time, place and person. There was slight difficulty in reading with paraphasia and difficulty in writing due to weakness in the right arm. She had nominal dysphasia. Cranial nerve examination showed bilateral optic atrophy with temporal pallor of the optic discs and paracentral scotoma. Muscle tone on passive manipulation of the limbs was increased in the right arm and leg. There was hemiparesis with severe weakness of the right arm and mild weakness in the right leg. A coarse, rhythmical tremor was noted in the right arm which was more evident in the proximal muscles. A slight tremor was also noted in the fingers of the outstretched left hand. There was dysmetria and intention tremor on finger-to-nose testing in both arms and the heel-to-shin test was clumsily performed on the right with dysmetria and ataxia. She required help to get up from bed and could stand with difficulty and walk a few steps with assistance but tended to fall to the left. All tendon reflexes were increased in the right arm and leg. The right plantar response was extensor and the left flexor. No abnormality was noted on testing sensation.

Laboratory Data: Lumbar puncture was performed. The initial pressure was 144 mm. of water. The cerebrospinal fluid was colorless and without cells. Protein content was 12 mgs. percent, sugar 73 mgs. percent and the chloride concentration was 123 meq/liter. Culture for bacteria and sereological tests for syphilis were negative. The colloidal gold curve was flat. Tests for metachromatic casts in the urine were negative. Shortly after admission to the hospital, the sodium content of the serum was 126 meq/liter. Potassium content was 3.8 meq/liter., chloride content was 93 meq/liter. and CO_2 content was 22.1 meq/liter. Subsequently, the serum electrolytes were restored to normal limits by appropriate intravenous fluids. The electroencephalogram showed normal alpha activity over the right hemisphere, but there was medium voltage slow activity in the theta and delta range over the left hemisphere. The blood count, culture and analysis of the urine, blood urea nitrogen, blood sugar, sedimentation rate, culture of the throat, blood culture, tests of the blood for febrile agglutinins, roentgenograms of the chest and skull were all within normal limits.

Clinical Diagnosis: A diagnosis of post-infectious leukoencephalitis was made based on the onset of symptoms of diffuse and patchy involvement of the central nervous system (left hemisphere, cerebellar and corticospinal systems and optic nerves) following a febrile illness.

Treatment: The child was placed on bed rest and given intravenous fluids. Methyl prednisolone (Medrol) was administered orally in the following dosage: 80 mg. every other day for eighteen days, 64 mg. on the twentieth and twenty-second days, 48 mg. on the twenty-fourth day, 32 mg. on the twenty-sixth day, 16 mg. on the twenty-eighth day and 8 mg. on the thirtieth day. The drug was then discontinued. After institute of therapy, progressive improvement was noted and by the time the course of treatment was completed the neurological examination was normal.

There have not been any symptoms for an interval of two years since discharged from hospital.

CASE 2: A 19-year-old white male was admitted to Harper Hospital on April 7, 1966, with a two month history of recurrent attacks of upper respiratory tract infections, sometimes accompanied with otitis media. Four days prior to admission, he awakened with a dull headache, nuchal rigidity, ataxia, dysarthria, nausea, blurring of vision, difficulty in reading and the complaint of numbness in both his hands and feet.

Neurological Examination: He was lethargic, but fully oriented with intact memory, speech, judgment and ability to read, write and calculate. The optic discs appeared moist and blurred at the edges. Vertical nystagmus was present and evidence of a bilateral inter-nuclear ophthalmoplegia with bilateral weakness and unilateral nystagmus of the abducting eye on gaze to either side. Bilateral ptosis was also present. There was weakness of the left lower face and the speech was dysarthric. The remaining cranial nerves were normal. The motor strength was normal. There was bilateral dysmetria and poor performance on tests of coordination in all four extremities and the gait was wide based and ataxic with a tendency to fall to either side. The deep tendon reflexes were slightly hyperactive, but both plantar responses were flexor. Pinprick sensation was diminished below both knees and both elbows.

Laboratory Data: The blood hemoglobin value was 13.96 gm. per 100 ml. with a hematocrit of 44.5%. The white cell count was 12,800 per cu. mm. with 64 percent polymorphonuclear cells, 15 percent band forms, 17 percent lymphocytes and 2 percent eosinophils. The sedimentation rate was 40 mm. in 1 hour. (Westergreen). The blood urea nitrogen content, fasting blood sugar level, serum calcium and phosphate levels, alkaline phosphatase level and serum protein electrophoresis were all within normal limits. Tests for serum heterophil antibodies, cold agglutinins and C reactive protein were negative. A lumbar puncture was performed on admission and showed normal pressures. The spinal fluid was colorless with 17 lymphocytes per cu. mm. The total protein was 30 mg. percent, the sugar content was 62 mg. percent and chloride content was 126 meq/liter. Serological tests for syphilis were negative and the colloidal gold curve test was flat. Bacterial cultures from the throat and from antral lavage revealed no growth.

For the first forty-eight hours after admission, the patient showed a progressive deterioration. He lost all visual percention in the left eye, and the funduscopic examination revealed evidence of papillitis due to optic neuritis. The left pupil reacted to light only on consensual testing. Cerebellar incoordination and intention tremor increased in the upper limbs and a sensory level appeared at T-4 with complete sensory loss below this level. A progressive paraparesis developed and the patient became unable to stand or walk with bladder paralysis and retention of urine requiring catheterization.

Clinical Diagnosis: The development of diffuse and patchy involvement of the central nervous system after a prolonged upper respiratory infection were judged to be characteristic of post-infectious leukoencephalomyelitis.

Treatment: Bed rest was instituted and methyl prednisolone (Medrol) 80 mg. was given orally every other day, from the fifth day following admission to the thirteenth day. The methyl prednisolone was then reduced to 64 mg. every other day from the fifteenth day of treatment and he was discharged on 48 mg. every other day on the twenty-first day. The patient improved progressively from the thirteenth day until he was discharged. There was a rapid return of bladder function and marked improvement in muscle strength in the lower extremities. His vision became 20/70 in the left eye without any visual field defect. He was able to walk with minimal ataxia.

Three weeks after discharge he was examined as an out-patient and there was complete resolution of symptoms and signs, and there has been no recurrence of symptoms in an 18 month period.

CASE 3: A 2½ year old white female was admitted to Harper Hospital on August 14, 1964, with an ataxic gait, paralysis of conjugate eye movements and lid retraction bilaterally. She had suffered from recurrent infections of the upper respiratory tract for approximately two months prior to admission. The general physical examination was within normal limits, except for a low grade fever.

Neurological Examination: Mentation was normal for her age. The visual fields were normal, but both optic discs appeared slightly swollen and blurred. Complete paralysis of all extraocular movements was present on attempted voluntary eye movements. Optokinetic nystagmus was absent in all directions. The remaining cranial nerves were intact. Tests for coordination showed moderate intention tremor and dysmetria bilaterally. Gait was wide-based with titubation of the head and marked truncal ataxia. The deep tendon reflexes were totally absent. The plantar responses were flexor. Motor strength and muscle tone were considered intact. Sensation was normal.

Laboratory Data: Lumbar puncture was performed on admission and the initial pressure was normal and the spinal fluid was colorless. There were 3 red blood cells, 7 lymphocytes and 2 polymorphonuclears per cu. mm. Cerebrospinal fluid

CO-AUTHORS

GILROY

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MEYER

protein content was 29 mg. percent, sugar content was 60 mg. percent and chloride content was 121 meq/liter. Cultures for bacteria and fungi were negative. The total white blood count was 12,500 per cu. mm. with a normal differential count. The sedimentation rate was 20 mm. in 1 hour. (Westergreen). Roentgenograms of the chest showed accentuated lung markings at the right base, possibly due to pneumonitis. Analysis of the urine was normal. Blood and spinal fluid serological tests for syphilis were negative. Blood urea nitrogen, electralytes, calcium, phosphorous and alkaline phosphatase levels were normal. Culture of the throat was negative. Roentgenograms of the skull and the electroencephalogram were normal.

Clinical Diagnosis: The sudden onset of diffuse neurological signs, including optic neuritis, paralysis of extraocular movements and cerebellar dysfunction in a child following an upper respiratory infection were judged compatible with the diagnosis of acute post-infectious leukoencephalitis.

Treatment: Fever persisted for the first five days of her admission and Penicillin in dosage of 600,000 units per day were given because of possible pneumonitis. Her neurological status remained unchanged. On the fifth day in hospital, Methyl Prednisolone (Medrol) was given in doses of 80 mg. every other day. Marked neurological improvement began on the tenth hospital day. The optic neuritis resolved and normal extraocular movements returned except for slight limitation of upward gaze. The cerebellar incoordination rapidly improved. At the time of discharge there was minimal ataxia of gait and all truncal ataxia disappeared. Methyl Prednisolone was gradually withdrawn beginning on the eleventh day and was discontinued after the twenty-first day.

Repeated examinations in the out-patient clinic have not shown any neurological abnormality or recurrence of symptoms.

CASE 4: This final case in the series is believed to be a case of Schilder's disease in which several remissions have resulted coincident with institution of therapy with corticosteroids over a 4 year interval and maintenance dosage for the past 8 months are believed to have prevented further attacks. He has been seen in consultation by Dr. Manuel Gomez, Chief, Pediatric Neurology Section, Mayo Clinic, Dr. Richmond S. Paine, Chief, Neurology Department, Babies Hospital, Washington, D. C., and Dr. Paul Woolley, Professor and Chairman, Department of Pediatrics, Wayne State University, all of whom concurred with the clinical diagnosis of Schilder's disease.

A 3-year-old white male was admitted to Harper Hospital on August 15, 1963. His parents gave a history of an upper respiratory infection unassociated with fever which had been treated with antibiotics. About three days after treatment of the infection and ten days after the onset of upper respiratory symptoms, be became ataxic and complained of double vision. He was admitted to another regional hospital where urinalysis, skull x-ray and cerebrospinal fluid examination were reported to be normal. An electroencephalogram showed left frontal slowing. By the 7th day of the neurological illness, he was unable to walk, and fell to the left in attempting to stand. A ventriculogram was performed by a consulting neurosurgeon to rule out a posterior fossa tumor and this was found to be normal. There was some improvement over the next two months, but in November, 1963, he rapidly deteriorated. He became dysarthric and his ataxia increased so that he could only stand or walk with difficulty. The family had noted weakness in the left leg. He was admitted to the Neurology Service of Harper Hospital on November 12, 1963, with hemiplegia following a generalized epileptic seizure.

Neurological Examination: The patient was drowsy, but after two hours of postictal sleep, he became alert and was oriented as to place and person. He had bilateral optic atrophy with pallor of the discs. The other cranial nerves were normal. He was unable to stand on either leg and the right leg was weak in all muscle groups. There was cerebellar tremor in both upper extremities. The right knee jerk was absent but other tendon reflexes were symmetrical and normal. Both plantar responses were flexor and the sensation was normal.

Laboratory Data: On lumbar puncture, the opening and closing pressures were normal and spinal fluid showed 4 lymphocytes per cu. mm. The Pandy was negative and the total protein content was 95 mg. percent. A complete myelogram was normal. The electroencephalogram showed diffuse symmetrical medium voltage theta activity without lateralization. An electromyogram and nerve conduction time were normal. Skin and gastrocnemius muscle biopsy were normal.

Treatment: He was treated with Phenobarbital for the seizure for several days. This was discontinued because of hyperactivity and sodium diphenylhydantoin (Dilantin) 50 mg. four times daily was substituted. He was given a three week course of methyl prednisolone (Medrol) 20 mg. every other day with marked improvement beginning after 5 days. At the time of discharge he was free of neurological signs and symptoms except for temporal pallor. He was readmitted on September 17, 1964, following a clonic seizure involving the left face, arm and leg which lasted about forty minutes. He had shown deterioration in vision and coordination for about two weeks preceding the seizure. He was treated with sodium diphenylhydantoin (Dilantin) 100 mg. and Phenobarbital 100 mg. intramuscularly.

Neurological Examination: The optic atrophy was now more marked on the left side and the visual acuity was 20/200 O.S. and 20/100 O.D. Upward gaze was impaired but other extraocular movements were normal. The left corneal reflex was decreased and there was a left lower facial weakness. The tongue was deviated to the left on protrusion. The left hand grip and flexion of the left elbow were weak. The left knee jerk was brisk, but other tendon reflexes were normal. The left plantar response was extensor and the right was flexor. Sensation was normal.

Laboratory Data: The lumbar puncture showed normal opening and closing pressures and the spinal fluid contained 72 lymphocytes and 11 polymorphonuclear cells. The protein content was 26 mg. percent. The sedimentation rate was 36 millimeters in the first hour (Westergreen). Serum electrophoresis showed an elevation of the alpha II globulin. An electroencephalogram showed a background of 4 to 5 per second high to moderate voltage theta activity, with occasional occipito-temporal spikes bilaterally. Routine laboratory investigations and a lumbar pneumoencephalogram were normal. During this admission, he complained of recurrent frontal and temporal headaches with nausea and vomiting and developed acute retention of urine. A cystometrogram showed impairment of bladder sensation.

Treatment: He was treated with sodium diphenylhydantoin (Dilantin) 50 mg. four times a day, bethanechol chloride (Urecholine Chloride) 5 mg. three times daily, and methyl prednisolone (Medrol) 60 mg. every other day. He again showed a rapid improvement and was discharged four weeks later on sodium diphenylhydantoin, 50 mg. four times daily. The steroids were gradually withdrawn.

The next admission was two weeks later when he became blind and ataxic and had a focal left-sided seizure and vomiting. He was stuporous and the optic atrophy was more marked. There was a left hemiplegia. Treatment was begun with Primidone, 125 mg. every night at bedtime, and 40 mg. Methyl Prednisolone every other day and he again responded. An electroretinogram by Dr. A. Ruedemann, Jr., was compatible with optic nerve degeneration. The Methyl Prednisolone was slowly reduced over the next 4 weeks but when it was reduced to 8 mg. every other day he began vomiting, his eyesight deteriorated, he became irritable, ataxic and unable to walk without assistance. He was again admitted to the hospital where neurological examination showed signs indicating diffuse cerebral, cerebellar and spinal cord disease. The EEG was now diffusely abnormal. The cerebrospinal fluid contained 72 lymphocytes and 11 polymorphonuclear leukocytes with a total protein content of 129 mg%.

Methyl Prednisolone, 60 mg. every other day, was reinstituted and he again improved. During subsequent follow-up visits, the dosage of Methyl Prednisolone was reduced gradually every six weeks by 8 mg. every other day, but was maintained at 16 mg. every other day for 12 months and then was discontinued.

The fifth admission was on May 8, 1966, due to status epilepticus lasting about 36 hours. On general physical examination, the temperature was 99 degrees Fahrenheit, the pulse was 136 beats per minute and the blood pressure was 100/70 mm. hg. There was slight neck stiffness and the throat was inflamed.

Neurological Examination: The patient remained drowsy for forty-eight hours after re-institution of steroid therapy in the form of Prednisone* and was aphasic for a week. Thereafter there was a gradual return of speech during the second week. There was bilateral optic atrophy. The deep tendon reflexes were normal except for absence of the ankle jerks. Both plantar responses were flexor. The sensation was normal. Coordination testing showed poor coordination and dysmetria. Gait was broad-based and ataxic.

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*Prednisone was kindly supplied in the form of Meticorten by the Schering Corporation.

Laboratory Data: On lumbar puncture, the opening and closing pressures were normal, but the spinal fluid showed 300 red blood cells, 8 lymphocytes and 24 polymorphonuclears. The protein content was 26 mg. percent, the glucose content 60 mg. percent and chloride content 26 meq/liter. The total white blood cell count was 23,000 per cu.mm. with polymorphonuclears 70%, bands 19% and lymphocytes 11%. An electroencephalogram showed diffuse high and medium voltage delta waves which were more marked over the left hemisphere and maximal over the left frontal and temporal regions. Subsequent electroencephalograms showed improvement with symmetrical moderate voltage delta and theta activity over both hemispheres. Urine analysis and repeated urine cultures were negative. The serum calcium and phosphorus content, alkaline phosphatase levels and serum protein electrophoresis were normal. The blood urea nitrogen and a two-hour postprandial blood sugar were normal, as were the serum electrolytes. Repeated blood counts, roentgenogram of the chest, tomography of the optic foramina and a radio active mercury brain scan were all normal. Repeated tests for metachromatic bodies in the urine were negative and the urinary amino acid levels were all normal. A small brain biopsy of cerebral cortex obtained from the right parietal lobe was reported to be within normal limits without evidence of neuronal inclusion bodies.

Treatment: Prednisone therapy, 80 mg. every other day, was reinstituted. He was treated with sodium amobarbital, 250 mg. intravenously, and sodium diphenylhydantoin, 100 mg. intramuscularly, for status epilepticus and his seizures ceased. He was then treated with sodium diphenylhydantoin, 50 mg. four times daily and primidone, 125 mg. twice daily. He was discharged one month later on sodium diphenylhydantoin, 50 mg. four times daily, primidone, 125 mg. twice daily and Prednisone, 60 mg. every other day. At the time of discharge, he was able to speak a complete sentence and was oriented to time, place and person. He had a mild ataxia but his gait had greatly improved.

Since discharge he has remained free from seizures, but both anticonvulsant and corticosteroid therapy have been continued. He has been maintained on Prednisone (Meticorten) 50 mg. every other day. There appears to be a mild degree of persisting intellectual impairment and optic atrophy. Other than this, his neurological examination is within normal limits and his vision is good despite the pallor of the optic discs.

Clinical Diagnosis: This boy has now suffered five attacks of acute neurological disorder, in each attack there has been evidence of diffuse involvement of the central nervous system. The signs have included blindness with optic atrophy, recurrent hemiparesis, epliptic seizures, aphasia and ataxia. Each attack appears to result in improvement of the neurological signs and maintenance therapy with 50 mgs. of prednisone every other day appears to have prevented further attacks.

Discussion

Primary demyelinating diseases of the central nervous system may be classified into three groups:

Group 1 The lipidosis and dysmyelinating diseases associated with storage of abnormal metabolic products. This group includes the classical lipidoses, such as Tay-Sachs disease.

Group 2 The familial leukodystrophies, including spongy degeneration of the central nervous system; sudanophilic leukodystrophy; globoid cell (Krabbe) leukodystrophy; leukodystrophy with diffuse Rosenthal Fiber Formation; Pelizaeus-Merzbacher disease; and Metachromatic leukodystrophy.

Group 3 The primary demyelinating diseases.

a) Schilder's disease.

b) Balo's disease.

c) Multiple sclerosis.

d) Neuromyelitis optica (Devic's disease)

e) Post and parainfectious leukoencephalitis.

f) Post vaccination leukoencephalitis.

g) Acute hemorrhagic leukoencephalopathy.

This paper is concerned with treatment of the demyelinating diseases classified here as Group 3 a) and e), namely Schilder's disease and post and parainfectious leukoencephalitis. Acute demyelinating diseases such as post-infectious leukoencephalitis, multiple sclerosis and Schilder's disease may show some spontaneous remissions which makes the interpretation of the effects of any treatment a difficult procedure. In the series of cases reported here, rapid improvement followed the use of steroids in each case and was so striking that it appeared to us that the treatment must have influenced the course of the disease. This impression was strikingly reinforced by the repeated and prompt response to steroid therapy shown in a whole series of acute exacerbations in the child with Schilder's disease and the cessation of further exacerbations with maintenance therapy for more than one year.

Almost all the reports in the literature have been concerned with the use of ACTH in the treatment of demyelinating diseases but whether the treatment was with ACTH or cortisol and its derivatives, side effects such as Cushing's syndrome with the continuous use of large doses imposed a serious limitation on the duration of treatment. This was the reason that we were hesitant at first to use maintenance dosage in the case with Schilder's disease. Fortunately the majority, if not all the side effects, can be abolished by the intermittent use of steroids. The intermittent program of therapy is based on the observation that the therapeutic effects of steroids appear to persist longer than the metabolic effects.[7] Intermittent dosage given every other day allows metabolic equilibrium to be restored between doses and minimizes or abolishes the harmful metabolic effects of large dosage while the anti-inflammatory effect is continued.

In practice, it has been found that a single dose of Methyl Prednisolone or Prednisone every other day is effective in the treatment of demyelinating diseases with little evidence of side effects. This has been particularly apparent in the case of Schilder's disease who is still being treated every other day with high dosage of steroids and has no signs of Cushing's disease.

While this form of intermittent steroid therapy is ideally suited for conditions requiring long-term treatment, we have found it equally effective in the short-term treatment of post-infectious leukoencephalitis where only a short period of treatment may be required, as in the three patients reported here.

The results of this study have indicated to us that if steroid therapy is used in the treatment of the acute exacerbation of multiple sclerosis, (a disease rarely affecting children but unfortunately a common problem in adult neurological practice) intermittent therapy should be used. This has now become the standard procedure in the Neurology Department at Harper Hospital. An additional benefit of this form of therapy is that it is less likely to cause adrenal cortical suppression even when given over a period of many months and symptoms of adrenal insufficiency are not seen during withdrawal of the drug.

Summary

Evidence that ACTH and corticosteroids are effective in the treatment of the demyelinating processes are cited both in experimental allergic encephalomylitis and in certain demyelinating diseases occurring in adults such as multiple sclerosis. Treatment has been limited by the development of serious side effects, such as Cushing's syndrome. Four cases are reported as evidence that corticosteroid therapy is effective in the treatment of post-infectious leukoencephalitis and in Schilder's disease.

The administration of methyl prednisolone (Medrol) or prednisone (Meticorten) in a single oral dose once every 48 hours permits adequate anti-inflammatory effects with restoration of metabolic equilibrium between doses and the reduction of side effects even with the long-term use of high doses. This form of therapy is recommended for the treatment of demyelinating diseases and

should be considered when long-term steroid therapy is indicated. ☐

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What is Current Thrust of MSMS In Communications, Public Relations?

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The November issue of *Michigan Medicine*, on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Various chapters of the book are being printed each month for all MSMS members to study. This month, Chapter Seven is printed in full.

Discussion

Medical Public Relations

MSMS had the earliest statewide, planned public relations program of any state medical association. It set many patterns of communication and public relations practice which have stood the profession in good stead over the years.

PR Plans

On the other hand, money for PR purposes has been progressively cut back over the last ten years, and plans have often remained just plans in Michigan whereas in other states these same plans supplied by Michigan have been adopted and implemented to the advantage of medicine.

Michigan Health Council

Michigan Association of the Professions

Much of the medical public relations and communication program of MSMS is now being fostered and financed by others. Of particular importance in this area are MAP and the Michigan Health Council. If their respective services were to be lost or diminished, the MSMS public relations program would be lost or diminished in direct proportion, although not to the same degree, because fine contributions are being made by MSMS membership and staff in the work of MAP and MHC.

Publicity Liaison

Also, outstanding efforts are succeeding in the respective fields of publicity and liaison with both communication media and opinion-molding groups and persons. Both have been perfected and followed through upon in Michigan better, perhaps, than anywhere else in the nation on either a local, state, or national level.

Communication with Membership

Overlooked in most public relations programs is the necessity of communicating with the association membership. This is one area which has been emphasized in the past few years in Michigan. Although the system is still not mature, it is being pointed to as exemplary by others and daily receives the accolade of imitation.

Financing

Many suggestions for improvement in communications with the public are inherent in the questions which follow. The main problem is not ideas or know-how but funds.

Ideas for communication with membership must overcome the competition of other printed media for the time the doctor has to read . . . or to use other media sufficiently intriguing to gain his attention and time.

Questions

MICHIGAN MEDICINE Weekly?

A. Would there be any advantages over the present journal of a weekly publication of MICHIGAN MEDICINE, but carrying no scientific papers, combined with a quarterly carrying a large collection of original scientific papers? This weekly publication would carry all organization news, legislation, meeting notices and reviews, news of governmental rule changes, special TV programs, etc., etc.

Continuous Physician Opinion Survey

B. Should a random sampling survey system be developed which could be used economically and at semi-monthly intervals to provide a continuing study of

1. Medical opinion of AMA and MSMS projects?
2. Physicians' reactions to local, state, and national events of health or professional importance?
3. A pretest of a variety of policies and plans of organized medicine?

Two-way Radio Network

C. Would a two-way radio network among the individual members and the MSMS headquarters and the component medical society headquarters be feasible? Such a network might supply music for doctors' offices, news scientific papers, etc. How can it be financed?

Public Speaking Classes

D. Would a course in public speaking on a three-session-per-year basis be patronized by MSMS and aid them in lecturing on MSMS policies and professional objectives?

Video Tape Recording

E. How efficacious would be a video tape system (tapes made nationally, state, and locally with statewide distribution and a headquarters library) in serving the purpose of communicating medical society programs and policies as well as scientific information?

Regional State Society Meetings

F. How valuable for communication purposes are meetings held around the state on a planned basis between officers of the MSMS and groups of CMS leaders? Should they be continued?

Handbook for Officers

G. Would an "MSMS Handbook for CMS Officers" be a valuable aid in communicating medical policy between state and component societies?

Liaison with Communication Media

H. How can closer liaison at the community level be established and maintained between organized medicine and newspapers? Radio? TV? Should the MSMS sponsor regional meetings between doctors and these media as was done some years ago? □

t's be specific about Campbell's Soups…

and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

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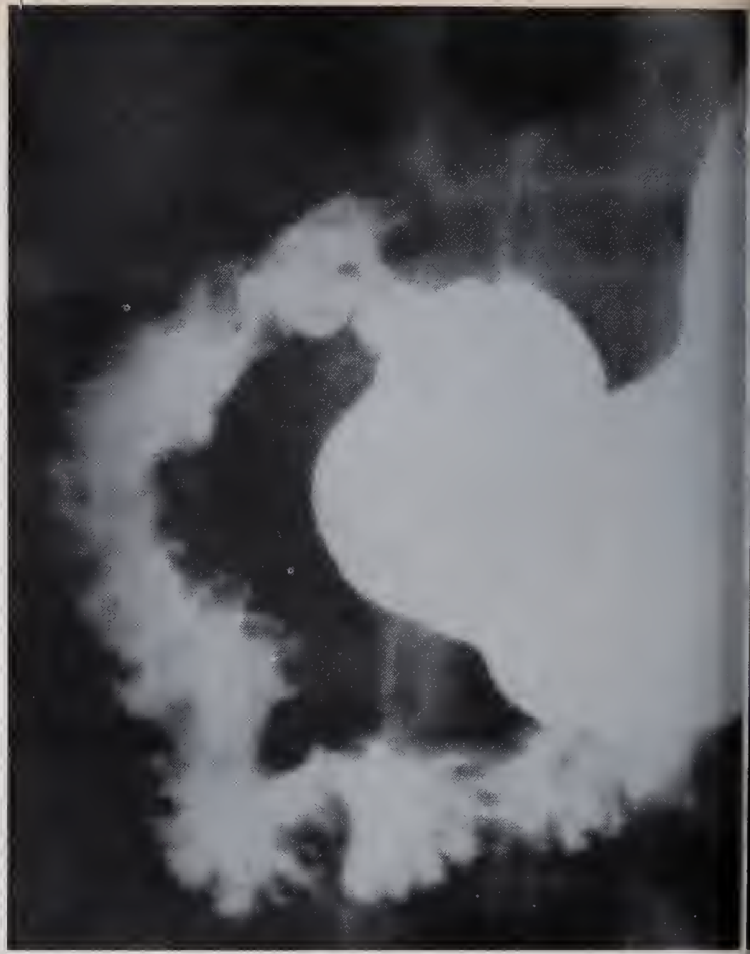
CONDENSED
SOUP

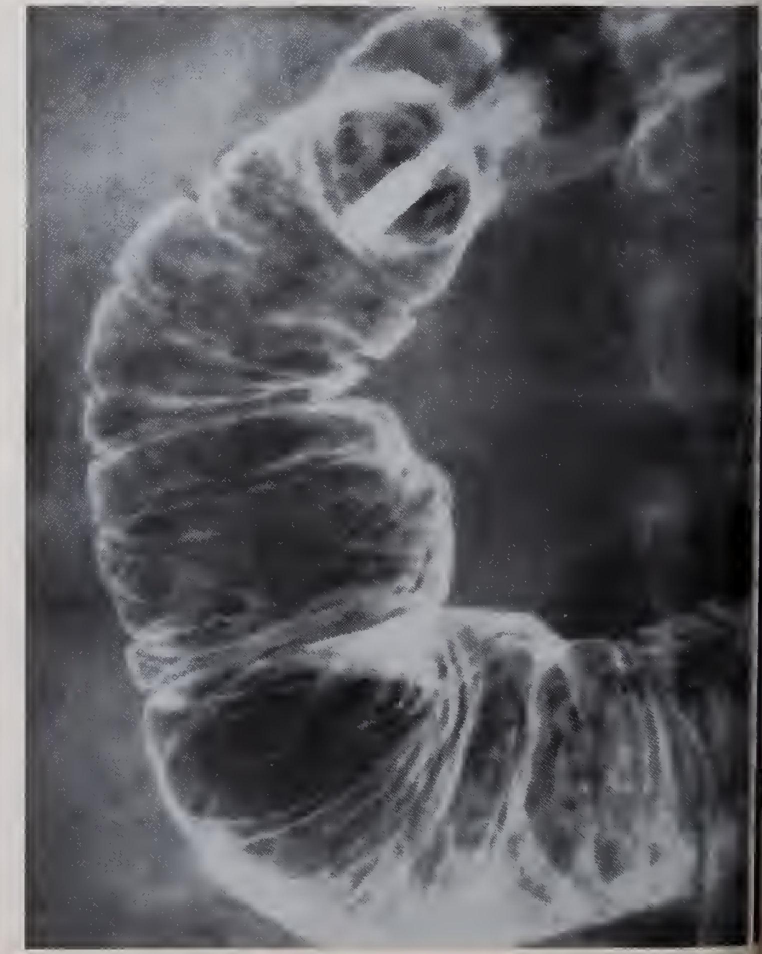
Conventional Radiography

The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive: Is this duodenum abnormal?



Hypotonic Duodenography

Pro-Banthīne-induced duodenal calm permits full anatomic appraisal: Same patient. Duodenal normality is now evident.



• in diagnosis
• in treatment

Pro-Banthīne® brand of propantheline bromide

calms the gastrointestinal tract

For fifteen years Pro-Banthīne has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthīne has reestablished its pharmacologic effectiveness in diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthīne. The duodenum was intubated. Pro-Banthīne in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89:*438-443 (Sept.) 1967.

SEARLE

Research in the Service of Medicine

"Breathing's a snap again," he said gingerly.
(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripher vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thromb cytopenia, have been reported on rare occasions. Drowsiness, lassitu nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

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in sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

SAMA TO HEAR ANN LANDERS

Problem-solver Ann Landers, whose husband is a Chicago physician, will speak on "The Young Doctor's Wife," on Friday, April 26 at the Student American Medical Association meeting.

The WSU SAMA will host the national convention, April 24-28.

PG Committee Adds Howell

A program at Howell for the Livingston County Medical Society will be a new offering this spring by the MSMS Committee on Postgraduate Medical Education.

A total of 20 programs will be presented this spring in Michigan by the MSMS Committee in cooperation with the three Michigan medical schools and the State Department of Public Health.

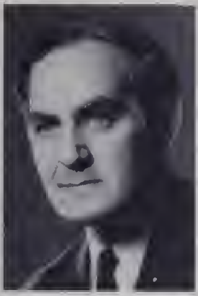
Following is a list of the communities which will host the programs, many of which will include a clinical demonstration and discussion:

Upper Peninsula

Houghton—Monday, May 13
Sault Ste. Marie—Monday, May 13
Manistique—Tuesday, May 14
Escanaba—Tuesday, May 14
Ironwood—Tuesday, May 14
Iron Mountain—Wednesday, May 15
Menominee—Wednesday, May 15
Marquette—Thursday, May 16

Lower Peninsula

Alpena—Thursday, April 18
Battle Creek—Tuesday, May 7
Cadillac—Thursday, May 23
Grayling—Thursday, April 25
Lansing—Date to be set
Howell—Tuesday, May 7
Midland—Thursday, May 9
Muskegon—Wednesday, May 15
Niles—Tuesday, May 21
Holland—Friday, May 3
Petoskey—Thursday, April 11



'68 Annual Session Cut To 2 Days, Sept. 25-26

Under the chairmanship of Alexander J. Walt, M.D., the 1968 Annual Session Planning Committee has developed the basic programs for the September meeting. To be held Wednesday and Thursday, September 25-26, at the Sheraton-Cadillac Hotel in Detroit, the Annual Session will involve two days of courses, general meetings, and section meetings.

The program, as currently developed, is as follows:

WEDNESDAY, SEPTEMBER 25

1) Section meetings: To be held throughout the day.

2) General meetings: The morning will be devoted to Problems of the Foetus and Breast Carcinoma. The afternoon will focus on Trauma, Pediatric Problems, and Relief of Pain.

3) Courses: To be held throughout the day on Infectious Diseases and Pulmonary Diseases.

At 8:00 p.m. the Annual State Society Dinner Dance will be held.

THURSDAY, SEPTEMBER 26

1) Section meetings: To be held throughout the day.

2) General meetings: The morning will be devoted to Cardiovascular Diseases and Prostate Carcinoma and Calcium. The afternoon will focus on Psychoanalytic Problems of the Aging Population and on What's New? For example, in the field of Transplantation, Cancer, Thyroid, Urology, Gynecology, Infectious Diseases, Shock, G-I Tract Diseases, Pediatrics.

3) Courses: To be held throughout the day on G-I Tract Diseases and Blood Diseases.

Members of the Annual Session Planning Committee are: Alexander J. Walt, M.D., chairman of the surgery department at Wayne State University Medical School, Chairman; T. A. Baker, M.D., West Branch; W. C. Baum, M.D., Grand Rapids; K. H. Johnson, M.D., Lansing; H. A. Towsley, M.D., and N. A. Vanselow, M.D., both of Ann Arbor; A. M. Lerner, M.D., F. P. Rhoades, M.D., Geoffrey L. Brinkman, M.D., R. F. Wilson, M.D., F B Bicknell, M.D., T. N. Evans, M.D., and W. S. Haubrich, M.D., all of Detroit.

The recommendation of the Planning Committee that the 1968 Annual Session be limited to two full days, rather than ending on Friday with a half-day program, was approved by The MSMS Council at its March meeting.

SPECIAL PROCEEDINGS FOLLOW BLUE PAGES — MSMS members may wish to pull out the four cream-colored pages immediately after the blue breaking-news pages in the middle of this issue. Members may want to read and file the official actions of the recent special meeting of the MSMS House of Delegates.

Pages may be removed easily now from the perfect-binding method used by *Michigan Medicine.*

Three Groups Elect Officers

Edwin DeJongh, M.D., clinical assistant professor of occupational medicine at Wayne State University, has been elected president of the American Academy of Occupational Medicine. Doctor DeJongh, who has served two terms on the board of directors of Industrial Medical Association, is now a member of the rehabilitation and screening committees of the Michigan Heart Association, a trustee of the Greater Detroit Council of Alcoholism and the Detroit Rehabilitation Center, and guest lecturer in the Institute of Industrial Health at the University of Michigan.

* * *

The Kent Medical Foundation at its annual meeting re-elected Fred C. Brace, M.D., president, and Charles A. Wilkinson, M.D., secretary-treasurer, for the coming year. Harold Bowman, M.D., and John R. Wilson, M.D., were elected to three-year terms on the board of trustees. The foundation seeks to promote careers in health fields through scholarships, loans and tuition grants.

* * *

The new officers of the Detroit Industrial Physicians Club were installed at a recent meeting. The new president is E. A. Shaptini, M.D.; president-elect, D. C. Laderach, M.D.; Secretary-Treasurer, M. S. Lechner, M.D.; and Member-at-Large, P. L. Neiswander, M.D.

TO DRAFT ALIENS

A check is being made to determine how many alien physicians, dentists and "allied specialists" are now subject to draft laws. A new law for the first time makes aliens in the medical and dental professions subject to draft up to age 35.

Slagle Keynotes Socio-Econ Congress

Three Michigan physicians spoke at the 2nd National Congress on the Socio-Economics of Health Care in Chicago, March 22-23. George W. Slagle, M.D., Battle Creek, was chairman of the Congress.

Doctor Slagle, also chairman of the AMA Council on Medical Service, opened the two-day meeting outlining "Goals of the Congress." James T. Howell, M.D., executive director of the Henry Ford Hospital, Detroit, addressed the group on "Group Practice in Action — Its Effect on Quality of Care," and Vergil N. Slee, M.D., Ann Arbor, director of the Commission on Professional and Hospital Activities, spoke about "The Physician as an Evaluator of Care."

Doctors Help Plan Hospital Conference

Three physicians are serving on the planning committee for the 1968 Medical Staff-Trustee-Administrator Forum to be held May 8 through May 11 at the Boyne Mountain Lodge. Julien Priver, M.D., executive vice-president of Sinai Hospital of Detroit, is chairman of the planning committee. William H. Meade, M.D., Lansing, and Roger B. Nelson, M.D., Ann Arbor, are also members of the committee.

The meeting is being sponsored jointly by the Michigan Hospital Association, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons, and Michigan Osteopathic Hospital Association to develop better communications between hospital medical staffs, trustees, and administrators.

SOCIAL SECURITY EXPERIMENTS WITH PAYMENT PLANS

Social Security Commissioner Robert M. Ball, following President Johnson's Health Message recently announced an experimental program to find methods of reimbursing hospitals and doctors that will have built-in incentives to efficiency and economy.

The medicaid and maternal and child health programs, as well as the medicare program, will be involved in some of the experiments, the Commissioner said.

Participation, which is entirely voluntary, will be welcomed from hospitals, physicians, and health care organizations and institutions. A panel of experts will evaluate and select proposals for experimentation.

Experiments which turn out favorably, Commissioner Ball said, may benefit the entire health care system, private as well as governmental. The present system of reimbursement under medicare may be waived for the experimental projects, he said.

Hypertension, Topic At Lansing, May 23

A "Spring Hypertension Symposium" will be held at E. W. Sparrow Hospital, Lansing, Thursday, May 23, co-sponsored by E. W. Sparrow Hospital, the Ingham County Medical Society and MSU College of Human Medicine.

Speakers will include Ralph Straffon, M.D., Cleveland Clinic; Edward D. Freis, M.D., Washington, D.C.; A. A. Hodari, M.D., Henry Ford Hospital; S. W. Hoobler, M.D., University of Michigan and F. J. Haddy, M.D., Michigan State University. The morning and afternoon discussion seminars will be followed by a dinner at the Elks Club with "Duffy" Daugherty as the speaker.

Extract of March Council Meeting

Following are some highlights of the March 6 meeting of The MSMS Council:

Guest of The Council at luncheon was the new Director of the Michigan Department of Mental Health, William Anderson, M.D.

The Council nominated for the two vacancies on the Michigan Hospital Service Board of Trustees incumbent Wm. S. Reveno, M.D., incumbent Herbert W. Harris, M.D., and A. Carl Stander, M.D.

Appointed to the Medical Advisory Committee of the Blue Shield Utilization Review Project was D. F. Sarapo, M.D., of Adrian.

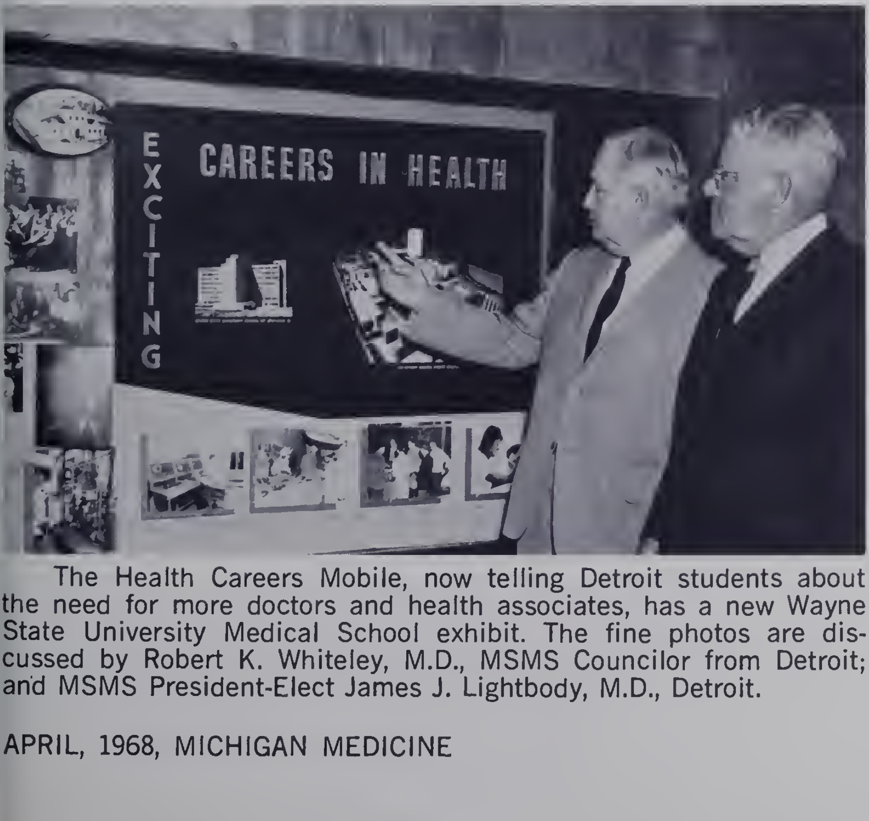
FOLLOWING THE approval, by the Special Session of the House of Delegates, of the new MSMS Asset Management Plan, The Council adopted a set of basic procedures and appointed a 5-man Board of Managers: Treasurer John R. Ylvisaker, M.D.; Finance Chairman Robert K. Whiteley, M.D.; C. Allen Payne, M.D.; Ross V. Taylor, M.D.; and Mr. Thomas Wagner. Executive staff assistant will be Warren F. Tryloff.

Upon the invitation of the Michigan Arthritis Foundation MSMS will co-sponsor a two-day Conference on Arthritis, May 11-12, Detroit.

Fifty copies of *Michigan Medicine* will be presented at no cost to senior medical students at each medical school in Michigan.

The Council recommended that the adjudication appeal mechanisms available to Michigan Medical Service be made available to other insurance carriers through existing adjudication mechanisms.

THE COUNCIL approved a recommendation of the Public Health Committee that, because MSMS wishes to aid in protecting the public and physicians from the hazards of defective radiation equipment, it recommends that in problem cases the chief of the MDPH Radiation Section consult with the Public Health Committee's advisors on radiation, who in turn can contact the physician in person or notify the component medical society of the violation. If, after contact is made, the physician still fails to comply, the Chief will contact a law enforcement agency.



The Health Careers Mobile, now telling Detroit students about the need for more doctors and health associates, has a new Wayne State University Medical School exhibit. The fine photos are discussed by Robert K. Whiteley, M.D., MSMS Councilor from Detroit; and MSMS President-Elect James J. Lightbody, M.D., Detroit.

The Council approved a recommendation of the Committee on Governmental Medical Care Programs that The Council should acquaint every member and every component medical society with the extreme necessity and importance of every physician becoming actively involved with all possible private and public health organizations concerned with every aspect of health and related fields at all local and state levels. Further, The Council should communicate with all component societies urging each to strongly suggest to their entire membership that, when health planning and similar organizations request them to serve, they ask the organization to channel the request through the component medical society and themselves notify their component medical society that they have been approached. Further, The Council communication should also urge every component medical society to contact all health planning and similar organizations in its area and offer to cooperate in the selection of appropriate medical members for their board and committees, and should maintain an accurate roster of all members serving in such capacities.

THE RESOLUTION of the Maternal Health Committee re Teaching of Family Life and Sex Education in Michigan Public Schools was approved. The full text of the resolution will appear in next month's *Michigan Medicine.*

Upon recommendation of the Committee on Maternal Health, The Council will urge the Department of Public Health to continue and improve comparative studies of perinatal mortality and morbidity in hospitals.

The Council authorized an outstanding health service award to the Michigan Congress of Parents and Teachers (PTA).

HEALTH PLANNING EXECUTIVE NAMED

Mrs. Betty Tableman has been named by Governor Romney to be executive director of the Comprehensive State Health Planning Commission (PL 89-749).

Appointed last August, the five-member Commission will oversee Comprehensive Health Planning in Michigan under recent federal legislation. Chairman of the Commission is R. G. Rice, M.D., Acting Director of the State Department of Public Health. Charles Orlebeke, an executive assistant in the Executive Office, is vice-chairman. Other Commission members include William H. Anderson, M.D., State Mental Health Director; R. Bernard Houston, State Social Services Director, and Glenn S. Allen, Jr., State Budget Director.

Mrs. Tableman was on the staff of the State Public Health Department for several years in planning activities.

AMA PAMPHLET TELLS REASONS FOR BELONGING

Why should I belong to the AMA?

A hundred or more clear-cut reasons are given in a new eight-page pamphlet entitled, "Make the Most of Your American Medical Association."

Suggested for distribution to prospective new members and others, the pamphlet highlights major services and materials available from the AMA, lists reference books, enumerates services and publications available on practice management, physician-patient relations and community service.

Medical societies may obtain review copies or quantity copies by writing the Program Services Department. Single copies are also available from the AMA, 535 N. Dearborn, Chicago, for members or prospective members.

GPs Complete Annual Clinic

The 22nd Annual Postgraduate Clinic sponsored by the Michigan Academy of General Practice at the Sheraton-Cadillac Hotel in Detroit, March 13-14, drew an estimated 700 physicians.

"The clinic went very well," commented Francis P. Rhoades, M.D., director of the scientific assembly committee. "We had 24 speakers from all over the United States, covering a wide variety of subjects. Also we had 32 outstanding scientific exhibits."

Six MDPAC, MSMS Leaders Participate In AMPAC School

Attending a two-day AMPAC National Workshop, March 9-10, in Washington, D.C., were MDPAC Leaders Vernon V. Bass, M.D., Saginaw; Donato F. Sarapo, M.D., Adrian; Edgar J. Geist, Jr., M.D., Rochester; John R. Franck, Jr., M.D., Wakefield; James J. Lightbody, M.D., Detroit; Frederick Van Duyne, M.D., Flint, and Ralph T. Wills, of the MSMS staff.

Leading off the program was Ernest B. Howard, M.D., AMA Assistant Executive Vice President, who outlined the challenge which medicine faces and the contribution which the PAC movement can make.

"As a citizen responsible to his nation, the PAC physician is called upon to seek good government through the political process of electing good men," he said. "That adds to his load. But if he will shoulder both burdens manfully, we have it within our capacity to preserve an unrivalled system of health care and an unmatched heritage of freedom."

NEWS; AND ITS BRIEF

Matthew S. Hurth, M.D., Lansing, received the B'nai B'rith Human Relations Award at the 10th Annual Brotherhood Banquet, co-sponsored by the Community Services Council and B'nai B'rith.

Doctor Hurth, who has contributed his services as athletic physician to Gabriels and Resurrection high schools for many years, was honored for constantly placing "service to mankind above money."

A special award was given to Lieutenant Governor William Milliken for his efforts in the Ingham County Family-to-Family Volunteer Services project.

After a brief suspension caused by Viet Cong attacks on the cities, the AMA Volunteer Physicians for Vietnam Program is back in operation.

* * *

President Johnson asked Congress for $571.7 million more for medicaid for the 1968 fiscal year ending July 1, 1968.

The administration said the initial appropriation proved inadequate because of a complete lack of data and experience as to costs of such a program and a larger increase than expected in costs of hospital and other medical care.

Michigan State Medical Society
Special Session of the House of Delegates
February 14, 1968

1. Call to Order

A Special Session of the 1967 House of Delegates of the Michigan State Medical Society convened at 1:55 p.m. in the Auditorium of the Wayne County Medical Society, 1010 Antietam Road, Detroit, Michigan, with James B. Blodgett, MD, Speaker of the House, presiding.

2. Report of Credentials Committee

Chairman K. T. McGunegle, MD, reported, "There are 111 delegates seated. A majority are not from any one county."

3. Speaker's Remarks — James B. Blodgett, MD

The Speaker reviewed the purpose of the Special Session, called by the Speaker, at the request of The Council, to consider a proposed new asset management plan for the Michigan State Medical Society.

Assisting the Speaker were MSMS Legal Counsel A. Stewart Kerr; Parliamentarian Charles King, Dean, Detroit College of Law; Secretary Kenneth H. Johnson, MD; and Vice-Speaker Vernon V. Bass, MD.

4. Vice-Speaker's Remarks — Vernon V. Bass, MD

At the request of the Speaker, Doctor Bass reviewed the actions of the 1967 House of Delegates on the Ways and Means Reference Committee report, as follows:

"The Reference Committee on Ways and Means, S. N. Kelso, Jr., MD, Chairman, reported as follows:

"This Reference Committee approves in principle the recommendations of the Treasurer's Report and also the recommendations of the Committee to Study the Financial Structure of MSMS. However, because of the newer concept of financing proposed, the Reference Committee feels that the members of the House of Delegates should have more time to better acquaint themselves with the proposed changes.

"Your Reference Committee recommends that a committee of the House of Delegates be appointed to further consider this proposal and further acquaint the county medical societies with the intent and implications of this proposal, the committee to be instructed to report back to the 1968 House of Delegates.

"The House amended the report so that it read: 'This Reference Committee approves in principle the recommendations of the Treasurer's Report and also the recommendations of the Committee to Study the Financial Structure of MSMS.' The House then adopted the report as amended."

5. Council Chairman's Remarks — Robert J. Mason, MD

The delegates today will consider a plan for revising the management of the State Society assets. A review of these events leading to this consideration may be helpful in your deliberations.

The MSMS Treasurer in 1966 undertook a review of the Society's investments, financing and reserve policies and informed The Council and its Finance Committee that he believed some modernization of our practice was in order. He was authorized to proceed in the development of specific recommendations for change. At various stages of refinement, these recommendations were presented to The Council as information. The plan in final form was presented to The Council's Finance Committee in July of 1967. The Finance Committee approved the plan after minor amendments, and its transmittal to the 1967 House of Delegates was authorized.

You may recall that this House approved "in principle" the plan for revision of asset management. The precise intent of the House was obscure to The Council which was responsible for the implementation of House instructions. The Council, therefore, authorized the Treasurer to refine the new asset management plan and to obtain written, specific commitments from the various parties involved, so that the specific and detailed final proposal implementation could be reviewed.

The details of the final plan were presented to The Council in November, 1967, studied for a month, approved by The Council at its December meeting and recommended to the House of Delegates for its approval at a special session.

While The Council favors the plan, it believed that the House must authorize its implementation.

In making the decision to call the House into special session, The Council considered all aspects of the situation.

First, before the asset management plan could be seriously studied, it was necessary for The Council and its Finance Committee to know just what terms, conditions and rate of interest could be obtained. This was done in writing as a specific bank commitment in November. It would be honored for a reasonable length of time, but not until next September when the House could consider it in regular session.

Because of this, and because of the fact that the interest rates were so favorable in a rising money market, The Council called a special session of the House to authorize implementation of the asset management plan.

The House then meets today in special session to consider this recommendation of The Council, and I quote:

"That the House of Delegates approve the plan for revising the management of MSMS assets, and authorize The Council to implement the plan in accordance with the By-laws as amended at this House."

And Mr. Speaker, with your permission, sir, I would like now to ask our Treasurer, Dr. John R. Ylvisaker, to address this august delegation and to highlight the details of the asset management proposal.

6. Treasurer's Report — John R. Ylvisaker, MD

Gentlemen, I have addressed you previously as a body and many of you individually or in groups. I have discussed with you the thought processes by which I formulated the financial program now recommended for adoption by MSMS. You have already been presented with the written transcript of my previous address and with two detailed reports which incorporate the essentials of the program, the financial data demonstrating the need of a responsible fiscal policy and the steps by which this program could satisfy such a need within the Society budget and out of the Society's present resources. You have studied this information, I am sure, and it requires no repetition.

It will be subject to questioning later, if you wish.

The proposed program is formulated to accomplish objectives which are essential to sound business administration and to the furtherance of the stated purpose for which the Society exists, namely:

1. The promotion of the science and art of medicine,

2. The protection of the public health, and

3. The betterment of the medical profession.

The objectives of the asset management plan are:

1. The retirement of current expenses out of current income (a positive rather than a negative cash flow position).

2. The proper management of debt both by securing such debt for the lender and by amortizing the amount within the Society budget with a progressive scheduled long-term retirement based on membership participation in the benefits which the debt has purchased for the Society.

3. The provision of funded reserves adequate to protect the Society against demands caused by recurring predictable capital needs as well as unpredictable contingency needs.

4. The establishment and initial funding of a service reserve or trust, the income and growth of which may provide resources for a positive service program consonant with the purposes and responsibilities of the Society.

5. The proper management of money derived from membership dues:

a. to provide fixed-dollar amounts sufficient to meet fixed-dollar needs;

b. to protect the purchasing power of dollars designated as long term reserves;

c. to achieve maximum income, stability and growth, where possible, to protect the membership against unwarranted additional cash demands either as dues or assessments.

The proposed program embodies all of the above. It acknowledges the debt of the Society and assigns this debt to its rightful position as a mortgage on the headquarters building. It mobilizes a dollar appreciation of the headquarters building, leaving intact a substantial equity position. It transfers this appreciation to essential fund categories to stabilize and further the function of the Society. It provides for debt retirement within the capabilities of the Society budget. It spreads this debt over the useful life of the building and apportions its cost progressively to succeeding current memberships.

However, this program has a recognized cost measured by the possible difference between the interest paid on borrowed money and the income/growth received from invested money. The program cannot and will not avert dues increase or assessments if increase in future operation should place such demand on the Society. Also, a portion of the funds would be subject to fluctuations of the general economy in times of recession as well as "boom," but would nevertheless retain value relative to the economy.

I should like to address myself to two recurring questions:

1. Does this program represent sound business practice?

2. Is it morally correct for the Society to invest monies derived from membership dues in income or growth producing investment vehicles?

At the request of The Council, written opinions concerning tax consequences and business policy were obtained from consultants retained by MSMS. The conclusion of the research by the Alexander Grant Company, a national accounting and tax consultant firm, was that there is no conflict of this program with present rules and regulations of the IRS. A review by A. Stewart Kerr, Legal Counsel of the firm of Sweeney, Dodd & Kerr, concurred with the conclusions of Alexander Grant and Company with the statement, "In summary, there are no tax objections in the near future to mortgaging and investing in the manner that you have suggested."

Dr. Clyde Hardwick, Professor of Economics, of the University of Detroit, drew the distinction between present asset management as "old economics" and the proposed program as "new economics," indicating that this proposal would "allow MSMS a flexible plan to roll, react, and adjust to the changing general economy." I should like to emphasize that none of the three consultants took a position of advice, of approval, or of disapproval.

My personal position is that the recommended program provides the Society with a considerable increase in financial protection and depth in all areas of responsibility, whether to members, employees, lenders, the public or posterity. It is morally less defensible not to provide adequate financial protection of the Society and its responsibilities than to pursue a philosophy and adopt a policy which dedicates itself to that end.

To satisfy further possible objections, I approached the Regional Office of the IRS, specifically the Division of Tax Exempt Organizations. Initially, I was informed a memorandum of opinion would be supplied. This was later withheld on a judgment basis only. However, the summary of long detailed conversations supported the conclusions of the Alexander Grant Company and Mr. Kerr whose opinions were discussed directly with the IRS officials.

For an independent, objective view of the fiscal policy involved, as well as of the propriety of the Society to engage in such a program including investment in income and growth instruments, I have taken several further steps. One of these was to approach an economist by the name of Dr. Zentz, a PhD who was previously with the Federal Reserve Board and now is Vice President of the Bank of the Commonwealth, and explained what the plan was and how we were preparing to implement this. He wrote me the following letter:

"Dear Dr. Ylvisaker:

"You have asked me what is common practice, and what Bank of the Commonwealth Trust Department recommendations would be concerning the investment of endowment and other longer-term funds of not-for-profit organizations such as the Michigan Medical Society.

"I can say with considerable confidence that common practice, both in this Bank and in the trust departments of major New York banks many times our size, is for such funds to be invested approximately ⅔ in common stock and ⅓ in fixed income securities. I would strongly recommend that, over the long run, new monies of this type be invested even more in stocks than this ratio indicates, and I feel confident that other major trust departments are making similar recommendations.

"The reason for this is quite simple. We recommend that some current income be foregone with the expectation of receiving greater future income. There is no other way to protect against continued further erosion in the purchasing power of the dollar. I believe this to be the only truly conservative way to invest, because it attempts to conserve the buying power of the funds invested. Past experience bears this out – not excluding 1929. Even if that year were picked as the time of investment, the investor would be considerably better off today, in terms of total income and value of a quality portfolio, than if investment had been made wholly in what we used to think of as conservative, gilt-edged debt issues.

"Cordially,

"Bill Zentz
Executive Vice President
Investments"

In addition, I have invited two gentlemen to be with us today for brief statements. I would like, Mr. Speaker, if I may have your permission, to provide the floor to each for a very brief statement as a part of my discussion. (Permission was granted.)

Both of these gentlemen are new acquaintances. They express their own opinions. I don't know what they are going to say. I have reviewed the program with them. I have indicated to them the areas in which I would hope they might make some remarks, and they are strictly on their own.

The first gentleman is Dr. Thomas Gies, who is Professor of Finance of the Graduate School of Business Administration of the University of Michigan. Dr. Gies.

Dr. Thomas Gies: It strikes me that very possibly what we are dealing with is the problem of the future, and how you people in conducting the affairs of your association should provide for its future, and you know this provides very considerable authority problems for all kinds of people who deal with this sort of issue.

The future has some surprises for all of us, I am sure, not least of all this Society. How do you responsibly provide for things that you cannot predict? The problem has two dimensions. The first is meeting your routine financial requirements. Things that you can pretty much guess are going to occur in 1968, in 1969 and 1970. These are ongoing sorts of expenses. Secondly, there are going to be some unpredictable expenses that will occur. They are events which you can't predict for yourselves, but which you must prepare for. Then there is another dimension, the matter of developing new types of services and new activities. This is not only in the form of events which impose themselves upon you and which you must meet, but rather these represent opportunities which you can take advantage of if you have funds.

How do you take care of these two or three kinds of problems? In the name of prudent management, it seems to me that my answer to you has to be if you want to go in a direction of developing a capital fund, it must be made up of a kind of asset which does not shrink in value, but which, in fact, grows in value. I can document this in whatever dimensions you would like to go.

I am not inclined to try to frighten people with a specter of a hyper-inflation in the United States. We are not going to have anything like that, but we are going to have periodic occasions when runs on the order of two percent a year, two and a half percent, three, and in 1968 it may turn out to be three and a half percent. It is that kind of inflation, but that kind of inflation erodes rather seriously the value of fixed income securities over long periods of time, as you who have bought bonds, savings bonds and other types of fixed income securities in the past very well understand.

This suggests to me then that one of your guidelines will be that you would like to acquire ownership of types of assets which are likely to advance at least as rapidly as the economy as a whole. This suggests that your society should be investing in some kind of equity assets. The most likely would be high grade common stocks or high grade common stocks combined with some limited amount of debt securities.

The substance of my urging would be at this point if you are interested in a capital investment program, it seems to me it makes some sense in terms of the long run future of this organization, that it should be one composed fairly heavily of equities securities.

John R. Ylvisaker, MD: Thank you, Dr. Gies. The next gentleman is Mr. John Eschrich, Account Executive, in charge of the Institutional Department of Merrill Lynch, Pierce, Fenner & Smith, Inc.

Mr. John Eschrich: Mr. Speaker, Gentlemen: All I'm going to do this afternoon is present the testimony of an expert witness. Not myself, but Mr. Russell Macklin who heads the Portfolio Department for Merrill Lynch, Pierce, Fenner & Smith in New York gave me the following statement:

"The principle of a funded program such as that proposed by Dr. Ylvisaker, is a common and well accepted practice. Churches, social organizations, welfare organizations and universities among others commonly use it. It is a sound method to program the future."

(The following report from Treasurer Ylvisaker was presented to the Delegates in printed form.)

PROPOSED REVISION OF MSMS ASSET MANAGEMENT[*]

A Program for Initiation and Implementation

I. Essential elements of proposed revision:

- A. Discontinuance of present line-of-credit borrowing for operational expenses.
- B. Establishment of three fund categories:
  - 1. **Operational fund** — revolving fund for current expenses.
    - a. Replenished annually by income from dues, advertising, booth sales, interest, etc.
    - b. Partially invested in interest-bearing short-term fixed-dollar securities on month-to-month programmed release.
  - 2. **Capital Reserve fund** — self-perpetuating fund for contingencies and replacement of depreciable fixed assets.
    - a. One-half invested in fixed-dollar interest-bearing securities.
    - b. One-half invested in high-grade negotiable securities providing dividend yield and growth.
    - c. Income and growth reinvested continuously providing reserve funds proportionate to growth of Society and its obligations.
  - 3. **Managed Investment fund** — growth fund for extended service to the Society, to component societies, and to members.
    - a. Investment and re-investment by 5-member Board of Trustees in bona fide investment vehicles for balanced portfolio to provide growth, income and stability.
    - b. Interest, dividends, other income and growth to provide continued growth of the fund and extended service.
  - 4. Initial funding by mortgaging of the MSMS headquarters building with long-term budgeted amortization of resultant mortgage debt.

II. Financial data pertinent to proposed revision:

A. Previous annual debt service data:

Year	Maximum Debt	Interest	Reserves	Dues
1961	$250,000	$5,000	$ 59,300	$ 75
1962	210,000	7,200	61,000	80
1963	160,000	6,100	83,000	80
1964	155,000	2,900	106,000	80
1965	245,000	3,000	110,000	80
1966	225,000	5,600	113,000	90
1967	155,000	4,000	122,000	100

B. Present needs:

1. Operational fund — maximum borrowing projected for operational expenses 1967	$180,000
2. Reserve funds — recommended increase	120,000
3. Managed investment fund for inflationary hedge and increased service	up to 350,000
	$650,000

C. 1967 budget items re MSMS headquarters building and assets

Income		Expenses	
Reserve funds	$7,000	Taxes	$16,000
Operational funds	300	Insurance	2,300
		Interest	4,000
		Equity	45,000
	$7,300		$67,300

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[*] *Revised to include actual, rather than projected, 1967 figures.*

D. Effect of mortgage financing on MSMS budget—cost/$100,000/year = $100,000 × 7.92% = $7,920 assuming 25-year mortgage at 6¼% interest.

1. Operational fund — $180,000

Income		Expenses	
Reserve fund	$7,000	Taxes	$16,000
Operational funds	10,000	Insurance	2,300
		Interest & equity	12,256
	$17,000		$30,556

Decrease in debt service
$67,300 — 30,500 = $36,800
Increase in interest income
$17,000 — 7,300 = 9,700
Increase in cash available for budget or reserves Total $46,500

2. Capital Reserve fund — $120,000

Income		Expenses	
Reserve fund	$13,000 + growth	Taxes	$16,000
		Insurance	2,300
Operational fund	10,000	Interest & equity	23,760
	$23,000 + growth		$42,060

Decrease in debt service
$67,300 — 42,000 = $25,300
Increase in income $23,000 — 7,300 = 15,700
Increase in cash available for budget or reserves Total $41,000 + growth on $120,000

3. Managed Investment fund — $350,000

Income		Expenses	
Reserve fund	$13,000 + growth	Taxes	$16,000
		Insurance	2,300
Operational fund	10,000	Interest & Equity	51,400
Managed Investment fund	10,500 + growth		
	$33,500 + growth		$69,700

Increase in income $33,500 — 7,300 = $26,200
Increase in debt service
$69,700 — 67,300 = —2,400
Increase in cash available for budget reserves and service Total $23,800 + growth on $470,000

III. Proposal:

A. Accept Michigan National Bank mortgage

Amount	up to $650,000
Interest	6¼%
Term	25 years
Commitment fee	None
Prepayment penalties	None
Draw privileges	$50,000 or more per draw

B. Borrow (or draw) in sequence according to the following priority:

1. Operational funds $180,000
   a. Completion of borrowing March, 1968.
   b. Council review for authorization to proceed to second step.
2. Capital reserve funds $120,000
   a. Completion of borrowing by July, 1968.
   b. Second Council review for authorization to proceed to third step.
3. Managed investment fund up to $350,000
   a. Borrowing period July, 1968 to July, 1969.
   b. Monthly Council review.
   c. Council authorization for each $100,000 of borrowing.
4. Establishment of 5-member Board of Trustees for investment of Capital Reserve funds and Managed Investment funds—to be accomplished by March, 1968.

A lengthy period of questions and answers ensued.

THE HOUSE then adopted, by a roll call vote, a motion "that the Treasurer's Report be adopted and approved, and further that The Council implement these recommendations immediately and expeditiously."

7. Consideration of Necessary Bylaws Amendments to Implement the Asset Management Plan.

The following proposed amendments were read:

Add a new paragraph [Chapter 9, Section 8 (i)] to read:

"It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge or hypothecation. It shall have the authority specifically to authorize The Council and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid."

Add a new paragraph [Chapter 10, Section 8, subdivision (a)] to read:

"The Council shall have the authority to borrow money upon the general credit of the Society. The Council shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Council shall authorize and empower the President or the Chairman of The Council, and the Secretary or the Treasurer to execute such instruments as may be required."

This was the first reading of the Bylaws Changes.

These changes were referred to the 1967 Reference Committee on Constitution and Bylaws, C. J. France, MD, Chairman.

The House recessed for a brief period so that the reference committee could consider the matters referred to it.

THE REFERENCE COMMITTEE on Constitution and Bylaws reported, when the House reconvened: "Your Reference Committee has considered the Bylaws and first addressed itself to the question of whether the proposed Bylaws changes were consonant with the Constitution, specifically Article XII entitled 'Finances,' and particularly Section 1, which reads: 'The Method of Financing. Funds for meeting the expenses of the Society shall be raised by annual dues, special assessment and voluntary contributions.' The majority of the Committee took the point of view that there was no conflict with Article XII.

"Secondly, the amendment to Chapter 9 of the Bylaws, which is entitled 'House of Delegates,' Section 8 which is entitled 'Powers and Duties of the House of Delegates,' by the addition of a new paragraph (i) was approved.

"Third, Chapter 10 of the Bylaws, which is entitled 'The Council,' Section 8 which is entitled 'Control of Funds,' with the addition of a subparagraph (a) was approved.

"Your Committee recommends approval of this Reference Committee report."

In accordance with the Bylaws, the proposed Bylaws changes were laid over for one meeting of the House.

The House adjourned for a period and reconvened at its second meeting at 5:00 p.m.

At this time the Bylaws changes were presented for the second reading.

THE HOUSE adopted the report of the Reference Committee on Constitution and Bylaws.

THE HOUSE adopted a motion "that this House of Delegates sitting in Special Session authorize The Council to mortgage the corporation's building in East Lansing and to authorize The Council and its officers to execute such instruments as may be appropriate.

The House adjourned at 5:10 p.m.

Abbott Antihypertensive Building Blocks

A simplified approach
to the practical management
of hypertension

PIDINE
PARGYLINE
METHYCLOTHIAZIDE
DESERPIDINE
PIDINE
PARGYLINE
DESERPIDINE
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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
100 No. 6812
ENDURON
METHYCLO-
THIAZIDE
5 mg.

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patien sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persists for a full 24 hou With Enduron you can prescribe convenient once-a-day dosa without skimping your patients on day-long thiazide effectivene

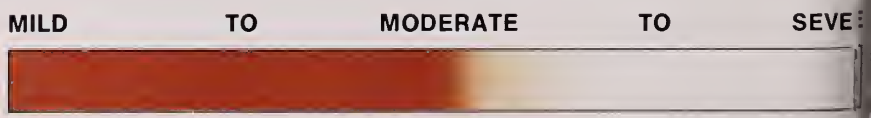
Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mc-erate hypertension. A single 5-mg. tablet each day is ample most cases.

Once a day, every day

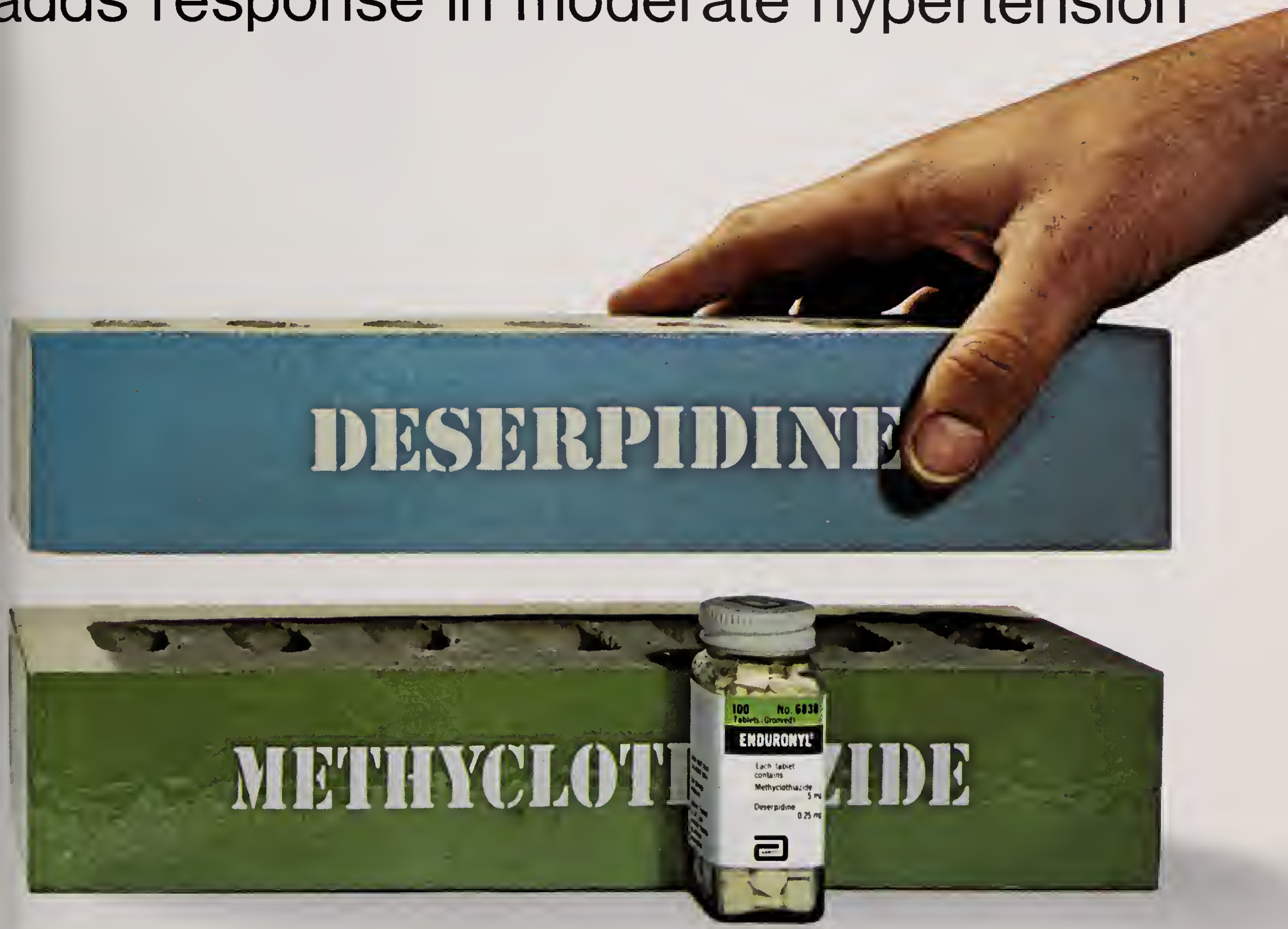
ENDURON

METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension


DESERPIDINE
METHYCLOTHIAZIDE
100 No. 6030
Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

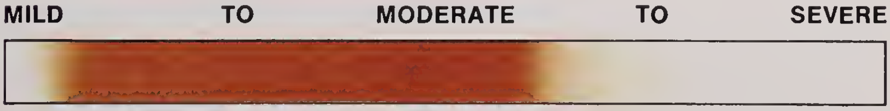
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

ETHYCLOTHIAZIDE 5 mg. with
ESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



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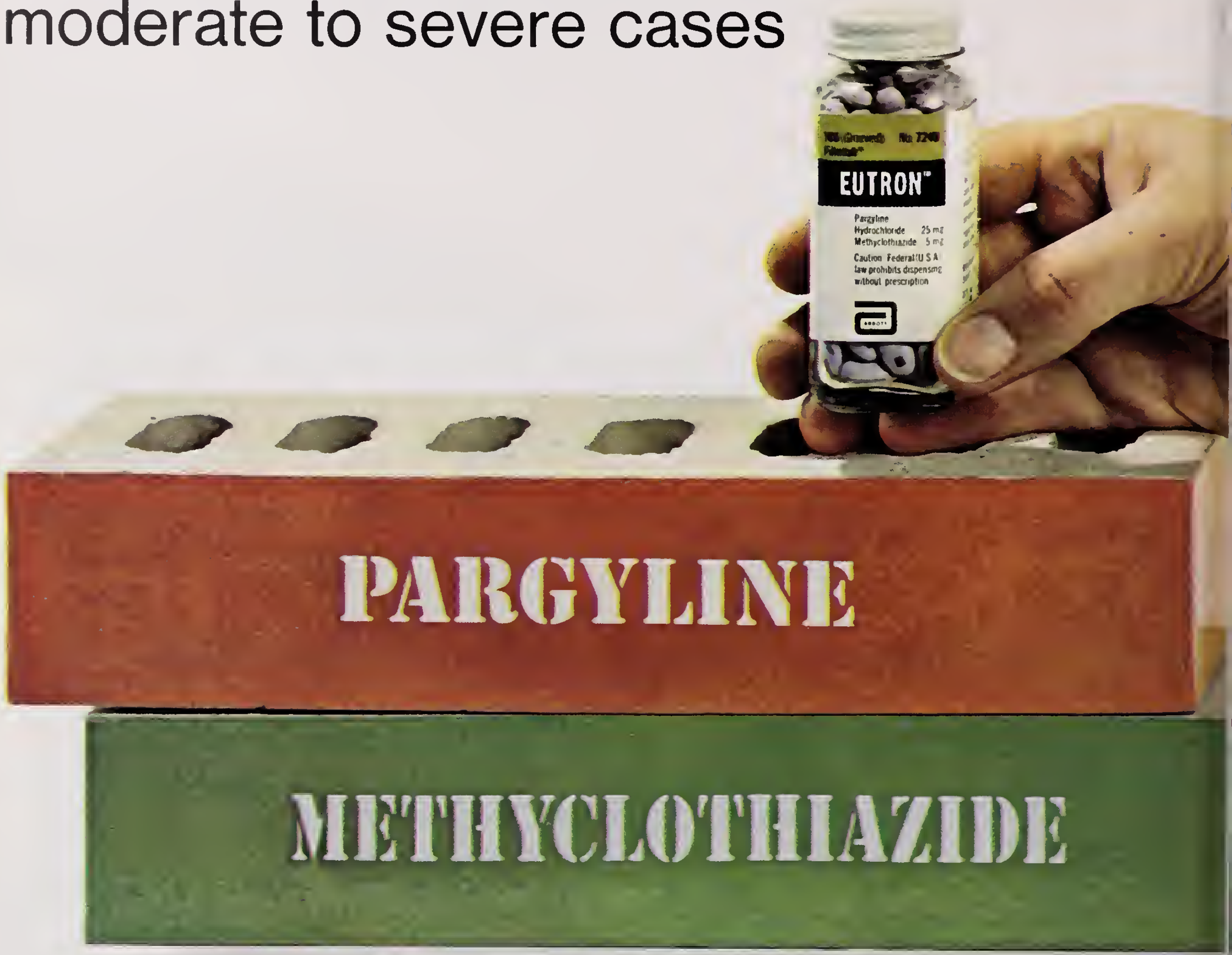
801094

Eutron: A unique combination for handling moderate to severe cases


EUTRON
Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal (U.S.A.) law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether you patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings wer reduced from 112 pre-treatment to 90 post-treatment; *sitting* fron 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearl alike in all three body positions.

Use Eutron for managing your moderate to severe cases. It building blocks enhance each other; hence lesser doses often suffice

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVER

See Brief Summary on final page of advertisement

8010

ENDURON®

METHYCLOTHIAZIDE

ENDURONYL®

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

MSMS Presents Awards to Recognize Legislators, Firms, Physicians

Twenty-four coveted MSMS Awards were presented at the 1968 Awards Luncheon in Detroit February 24 as part of the First Annual Michigan Conference Health Planning.

Twelve Michigan public officials, associations, firms and foundations received "Outstanding Health Service Awards." Two MSMS members were given "Distinguished Service Awards." Ten MSMS members received the new "MSMS Flag Awards" for their leadership as presidents of nonmedical, lay statewide organizations.

(See Viewpoints, page 441, for further information about The Flag Award)

Following is a complete list of the awards, and the special citations on the handsome certificates:

Michigan State Medical Society Outstanding Health Service Awards:

Clara Elizabeth Fund (Flint)
"For generous financial sponsorship of the annual Michigan Conference on Maternal and Perinatal Welfare, convened in cooperation with the Michigan State Medical Society"

Consumers Power Company (Jackson)
"For continuing financial support to the Michigan Health Careers Mobile and other programs of health career recruitment"

Charles E. Forsythe (Secretary, Michigan High School Athletic Association, Lansing)
"For distinguished leadership in helping to solve the medical problems related to organized high school athletics in Michigan"

Grand Rapids Press
"For outstanding reporting and interpretation of news about medicine and health"

James M. Hare, Secretary of State
"For outstanding cooperation with the Michigan State Medical Society in mutual efforts to remove the unsafe driver from Michigan highways as exemplified in the Medi-Label project"

Michigan Association of the Professions
"For continuing origination of the outstanding television program, "Formula," over WJIM-TV, Lansing"

Outdoor Advertising Association of Michigan
"For outstanding cooperation in making many billboards throughout Michigan available for a special health careers recruitment appeal"

Senator Robert L. Richardson (Saginaw)
"For leadership in supporting desirable health legislation for the people of Michigan"

Sears-Roebuck Foundation (Chicago)
"For generous financial support to the Michigan Health Careers Mobile and its program of health careers recruitment"

Representative J. Robert Traxler (Bay City)
"For leadership in supporting desirable health legislation for the people of Michigan"

The Upjohn Company (Kalamazoo)
"For continuing financial support of the important MD Placement Program of the Michigan Health Council and the Michigan Health Careers Mobile"

HEALTH
PLANNI
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Clara Elizabeth Fund;
George Whyel, representative

HEALTH
PLANNING
CONFERENCE
Consumers Power Company;
Wm. N. McClelland,
representative

PLANN
ONFER
Charles E. Forsythe

Photos of More MSMS Award Recipients:

HEALTH
ANNING
FERENCE

Grand Rapids Press; William Schieffel, Science Writer

MICHIGAN
HEALTH
PLANNING
CONFERE

Secretary of State James M. Hare

HEALTH
PLANNING
CONFEREN

Michigan Association of the Professions; Elmer Manson, Vice-President

Outdoor Advertising Association of Michigan; Tim Tobin, representative

HEALTH
PLANNING
C RENCE

Senator Robert L. Richardson

HEALTH
PLANNING
CONFERENCE

Sears-Roebuck Foundation; A. D. Swift, Detroit

WJIM-TV (Lansing)
"For continuing presentation of the outstanding television program, "Formula," in cooperation with the Michigan Association of the Professions"

* * *

Michigan State Medical Society Distinguished Service Awards

James S. Feurig, M.D. (East Lansing)
"For exemplary leadership in solving medical problems related to organized athletics in Michigan and the Nation"

Gerald A. O'Connor, M.D. (Ann Arbor)
"For exemplary leadership in solving medical problems related to organized athletics in Michigan and the Nation"

Michigan State Medical Society Flag Awards

Carl B. Beeman, M.D. (Grand Rapids)
President of Michigan Heart Association

Donald A. Hagge, M.D. (Livonia)
President of Michigan Archaeology Society

John J. Hanlon, M.D. (Detroit)
President of Michigan Public Health Association

William N. Hubbard, Jr., M.D. (Ann Arbor)
President of Michigan Association for Regional Medical Programs

Benjamin Jeffries, M.D. (Detroit)
President of Michigan Epilepsy Center and Association

MSMS Also Saluted These Firms, Men:

HEALTH
PLANNING
FERENCE

Representative
J. Robert Traxler

HEALTH
PLANNING
CONFEREN

The Upjohn Company; Donald
Meredith, representative

MICHIGAN
HEALTH
PLANNING
FERENCE

WJIM-TV, Lansing;
Harold A. Gross, President

George D. Maniaci, M.D. (Gladstone)
President of Michigan Association for Retarded Children

G. Frederick Moench, M.D. (Midland)
President of Michigan Society for Better Hearing and Speech

John B. Rowe, M.D. (Flint)
President of Michigan Diabetes Association

G. B. Saltonstall, M.D. (Charlevoix)
President of Michigan Association of the Professions

H. A. Towsley, M.D. (Ann Arbor)
President of Michigan Health Council, and Michigan United Fund

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Doctor, May I Have a Political Appointment

BY REP. JAMES H. HEINZE
BATTLE CREEK

(Note: This guest article was written for *Michigan Medicine* by Representative James H. Heinze, Republican serving a district of Calhoun, Kalamazoo, and St. Joseph Counties. A retired lieutenant commander of the Navy, Mr. Heinze obtained the A.B. and LL.B. degrees from West Virginia University. He was first elected to the Michigan House in 1966.)

"Now, Doctor," I have a suggestion:

"Several 'healing arts' bills have come before the Michigan legislature. In each case laymen, unfamiliar with the details and principles of medical and 'health' disciplines, are called upon to make decisions defining certain elements of the 'healing arts' professions.

Quite frankly, we are confused and frustrated by our lack of sound and reliable information. It is often almost impossible to distinguish between objective and subjective advice and opinion. Rightly or wrongly we suspect professional jealousies and self-serving motives.

"THERE ARE A NUMBER of medical, para medical and technical professions and disciplines of the healing arts which are recognized by law, and for which statutory definitions and regulations are in effect. Under these circumstances, our job is to define properly and up-grade all of these legally recognized disciplines. For this purpose every member of the legislature needs expert, reasoned, and objective professional opinion and advice.

"It is, therefore, sincerely suggested that the state and local organizations representing medical doctors and the various divisions of specialists within that profession together with the osteopaths, optometrists, chiropractors and other disciplines undertake to set up, voluntarily, a coordinating body or committee of some kind to which the legislature can turn for objective assistance in the area of statutory regulation of these disciplines."

How would you respond, Doctor, to that suggestion? I proposed it quite sincerely to a number of my medical constituents last year while the legislature was considering several healing arts bills. This is one part of political action and deserves your consideration.

REAL AND EFFECTIVE political action, however, starts with involvement in a political party, whatever party most nearly approximates your philosophy. At this level you participate in the selection of candidates, in their campaigns, both primary and general, and in the formulation of party policy and financing of party activity. Many elements of society and industry are becoming more conscious of the necessity of this sort of involvement. Without it, the most intensive "last minute" effort to obtain consideration of your views and attitudes toward pending legislation can fall on deaf ears and be completely ineffective.

This means a budgeting of your time, an hour or two a week for political activity, committee meetings or some calls with your candidate. Anticipating your response, I hear the words, "But I'm a busy man. I have more patients than I can handle now. I can't afford to devote any substantial time to grass roots political activity."

Doctor, the hour is late. You can't afford not to! □

SAGINAW DOCTOR COMPLETES RESEARCH, SEES CHLORINE AS HEART MENACER

Joseph M. Price, M.D., Saginaw, has released in a 50-page report, his findings that "the basic cause of atherosclerosis and the resulting clinical entities such as heart attacks and strokes is chlorine — the chlorine contained in processed drinking water."

His conclusion is based on a 2½ year study using young chickens. In the report, he also traces the history of chlorine use in various parts of the world and indicates a "correlation between the introduction and widespread application of chlorination of water supplies and the origin and increasing incidence of heart attacks that is exceedingly difficult to explain away."

Doctor Price's experiments and conclusions were reported in an extensive feature article by John D. Tucker in the *Saginaw News.*

Doctor Price is now serving as a captain in the Medical Corps in Viet Nam. His father, Joseph A. Price, assisted in the research study.

COMING EVENTS

HEART ASSOCIATION SCIENTIFIC SPEAKERS SET FOR MAY 10-11

The Michigan Heart Association's 1968 Scientific Sessions, formerly held in February has been shifted to May 10 and 11. The location also has been changed from a downtown hotel to the Rackham Educational Memorial Building, 60 Farnsworth near Woodward, in the Detroit Cultural Center.

Hotel accomodations will be available at the nearby International Inn.

Reservation forms are available at the Heart Association offices, at 13100 Puritan, Detroit, Michigan 48227.

Theme of the session, worth seven credit hours to the American Academy of General Practice, will be the identification of various arrhythmias, their physiological implications and management.

The program, May 10, will include:

"Practical Management of Arrhythmias and Conduction Disturbances in Children" by Mary Allen Engle, M.D., Director of Pediatric Cardiology, New York Hospital – Cornell Medical Center; "Adrenergic Beta Receptors: Values and Hazards of their Blockage," Henry H. Swain, M.D., Professor of Pharmacology, University of Michigan Medical Center; "Errors in Diagnosis and Treatment of Arrhythmias and Conduction Disturbances," Robert O. Brandenburg, M.D., Chairman, Sections of Cardiology, Mayo Clinic.

The program, May 11, will offer:

"Future Trends in the Medical Treatment of Acute Myocardial Infarction," Paul N. Yu, M.D., Professor of Medicine and Head, Cardiopulmonary Unit, University of Rochester School of Medicine and Dentistry; Vice Chairman, Council on Clinical Cardiology, American Heart Association; "Future Trends in Surgery for Ischemic Heart Disease," Philip N. Sawyer, M.D., Professor of Surgery, Downstate Medical Center, State University of New York, Brooklyn, N.Y.; Wilson-Myers Lecture: "Electrophysiology of the Heart," Brian F. Hoffman, M.D., David Hosack, Professor of Pharmacology and Chairman, Department of Pharmacology, College of Physicians and Surgeons, Columbia University; "Treat the Patient, Not the Arrhythmia – and How To Do It," J. Willis Hurst, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Ga.; "Rhythm and Conduction Disturbances as Insurability Risks – A Practical Assessment," Francis F. Rosenbaum, M.D., Vice President, American Heart Association, Milwaukee; "Problems with Rhythm and Conduction in Patients with Congenital Heart Disease," Robert O. Brandenburg, M.D., Chairman, Sections of Cardiology, Mayo Clinic.

The program was the work of MHA's Scientific Sessions Committee chaired by Thomas James, M.D., said Dr. Carl B. Beeman, president of the Heart Association. Other members of the Committee are: James B. Blodgett, M.D., Muir Clapper, M.D., Martin Jaffee, M.D., Thomas A. Bruce, M.D., James F. Conway, Ph.D., M.D., and Park W. Willis, III, M.D. □

CANCER DAY SET AT FLINT, MAY 1

The Genesee County Medical Society invites all physicians to attend its Eighteenth Cancer Day, Wednesday, May 1, at the Merliss Brown Auditorium at Hurley Hospital in Flint.

Welcoming participants to the morning session will be H. Maxwell Golden, M.D., president of Genesee County Medical Society. Bradley Harris, M.D., MSMS president, will preside.

Three talks are slated for the morning: "Use of Pap Smears in Diagnosis and Control of Cancer," by W.A.D. Anderson, M.D., from the Department of Pathology, Jackson Memorial Hospital, Miami, Florida; "Radiation Therapy of Primary and Metastatic Lesions to the Brain," by Jean Bouchard, M.D., Radiologist-in-Chief, Professor and Chairman, Department of Radiology, McGill University, Royal Victoria Hospital, Montreal, Canada; "How Will the Recent Federal Legislation Affect the Physicians and Cancer Patients?" by Guy F. Robbins, M.D., Director of Planning, Memorial Sloan-Kettering Cancer Center, New York, N.Y.

Presiding at the afternoon session will be Andrew J. Hunt, Jr., M.D., Dean of the School of Human Medicine at Michigan State University. The three afternoon talks are: "Responses to Therapy of Children's Metastatic Cancer and Leukemia," by M. Lois Murphy, M.D., Chairman, Department of Pediatrics, Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.; "The

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In addition the AMA TV network will present more than 40 hours of convention news.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, June 19, 1968. Since space is limited, we suggest you make your reservations before June 3, 1968. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

SAN FRANCISCO, CALIFORNIA · JUNE 16-20, 1968

AMERICAN MEDICAL ASSOCIATION'S 117th ANNUAL CONVENTION · BROOKS HALL

CONTINUED: COMING EVENTS

Early Roentgen Diagnosis of Cancer of the Lung," by Benjamin Felson, M.D., Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio; and "Diagnosis and Management of Neoplasms of Lung and Esophagus," by Walter J. Burdette, Ph.D., M.D., Professor of Surgery and Resident Associate Director of the M.D. Anderson Hospital and Tumor Institute, University of Texas Medical Center, Houston, Texas. □

Detroit To Host Big Science Fair

The 19th International Science Fair will be held in Detroit, May 15-18.

The fair was held in Michigan once before in 1958 at Flint.

The International Fair pools the best exhibits from 10, 11, and 12th grade students who have entered their work in local science fairs.

At last year's International Fair, there were two award-winning exhibits from Michigan: one was a study of nuclear phenomenon by a student at Sault St. Marie, another was an "Electrophoretic Investigation of Protein Levels in Serum from Rats Infected with Babesia rodhaini," by a student from Holt.

The American Medical Association is one of the organizations which sponsors awards at the International Fair. Each year Citation plaques are given to one boy and one girl with best exhibits in the broad field of medical sciences or health, plus expenses-paid trip to exhibit at the annual AMA convention. Six or more Merit awards are also given. □

TEACHES ADVANCED AID FOR AMBULANCE PERSONNEL

An advanced First Aid course for ambulance drivers and attendants is being given by R. W. Lingenfelter, M.D., director of emergency services at Beyer Memorial Hospital, Ypsilanti.

The classes, offered in connection with the National Ambulance Training Institute, meet weekly for four hours. Twenty drivers and attendants of the Superior Ambulance Company are enrolled. Doctor Lingenfelter reports that all the drivers assigned in Washtenaw County and others from outside the county have attended. □

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GRIFFIN, ROUSE COMING TO DETROIT FOR SAMA EVENT

Michigan, which produced the Student American Medical Association's first president, Warren R. Mullen, M.D., now of Pentwater, will play host to the 18th Annual Meeting of SAMA, April 24-28, at the Statler Hilton Hotel, Detroit.

"This is an excellent opportunity to observe your colleagues of tomorrow in an atmosphere that will surprise, as well as warm the hearts of those who fear for the future of medicine," says SAMA President David Kindig, in extending an invitation to all Michigan doctors.

The 1968 meeting is being planned by the national SAMA officers and the three SAMA chapters in Michigan at Wayne State, University of Michigan and Michigan State.

Highlights will include a lecture April 25 by USPHS Surgeon General William H. Stewart, M.D.; a symposium on "The Care and Feeding of Hippies," on April 25; a speech by Michigan Senator Robert P. Griffin at the annual American Medical Political Action Committee April 26; and a symposium on "The Physician's Personal Problems" April 26.

AAGP President George E. Burket, Jr., M.D., Kingman, Kans., will be guest speaker at an April 26 luncheon sponsored by the Academy.

AMA President Milford O. Rouse, M.D., will speak April 27 at the annual luncheon sponsored by the AMA.

Interested physicians can register in advance by sending a letter (general registration fee $2.00 — Award Banquet and Reception $5.00 additional) with check or money order to: SAMA, 2635 Flossmoor Road, Flossmoor, Illinois 60422, to assure advance registration. □

Detroit to Salute WSU on June 13

The City of Detroit, under the leadership of 100 distinguished citizens, will honor Wayne State University's 100th Anniversary at a banquet June 13.

Timed to coincide with the 100th Anniversary date of the issuance of the charter to the School of Medicine, the first Wayne college, the banquet, to be held at 7:00 p.m. in Cobo Hall, will feature Erwin Canham, editor of *The Christian Science Monitor,* as its main speaker.

Honorary chairmen for the banquet are Mayor Jerome P. Cavanagh and Governor George Romney. General Chairman is Walker L. Cisler, chairman of the board of Detroit Edison. □

MEDISCENE

April 17 — The Council, MSMS Headquarters, East Lansing

April 17-18 — Annual Conference for Directors of Research in Medical Education, Kellogg Center, East Lansing

April 22-25 — Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

April 23-28 — 17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

April 24 — Michigan League for Nursing, Annual Meeting and Board of Directors Meeting, Mercy College Student Center, Detroit

April 24-25 — County Medical Care Facilities Conference, Kellogg Center, East Lansing

April 30-May 1 — Woman's Auxiliary Spring Conference, MSMS Headquarters and Kellogg Center, M.S.U., East Lansing

May 1 — Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8 — Mental Health Week

May 4 — Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 6-8 — Michigan United Fund, Kellogg Center, M.S.U., East Lansing

May 8-10 — Michigan Public Health Association, Annual Conference, Jack Tar Hotel, Lansing

May 10-11 — Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 17-18 — Junior Academy of Science, Kellogg Center, East Lansing

May 18 — Kresge Eye Institute Clinic Day, Detroit

May 18-19 — Pediatric Clinic Days

May 22 — Annual Muscle Symposium, Wayne County Medical Society, Detroit

June 5 — The Council, MSMS Headquarters, East Lansing

June 16-20 — 1968 AMA Annual Convention, San Francisco

June 28-29 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor □

ACTIVITIES, PROJECTS

COMMITTEE OFFERS MSMS SPEAKERS ABOUT ALCOHOLISM

Aware of the problem which the private practice physician faces in treating alcoholics, the Committee on Alcoholism and Drug Addiction has decided to continue its physician education effort in 1968.

Chairman Herbert A. Raskin, M.D., of Detroit, reports county medical societies, specialty societies, and chiefs of hospital staffs will be contacted and informed of the availability of committee members and other experts for speaking engagements.

"We hope to give the practitioner of general medicine the knowledge required for diagnosis and treatment of alcoholics," Doctor Raskin said. "Alcoholism involves medical, sociological, and psychiatric problems and we hope to help the physician deal with these."

Doctor Raskin says speakers are available to discuss "How to diagnose and treat alcoholism," "What can be done with the alcoholic in the hospital," "Requirements for post-hospitalization care," "Over-all picture of purely medical problems and the emotional factors involved," "Emotional factors which the non-psychiatric physician can handle," "Physician's role in terms of the sociological problems of the patient," and "Physician's role in the community public health problems involved in alcoholism."

Any hospitals or organizations having general or specific questions they want discussed should contact Herbert Raskin, M.D., at 18510 Meyers Road, Detroit 48235. Arrangements should be made, if possible, one month in advance of the speaking date. □

PRINTING OFFICE OFFERS NEW NATIONAL REPORT

Interested physicians may obtain copies of the *Report of The National Advisory Commission on Health Manpower* from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Price, 45 cents.

MDPAC ELECTS BASS, ANTHONY, LAHTI; HONORS COLE

At its recent meeting in Detroit, the Michigan Doctors Political Action Committee re-elected Vernon V. Bass, M.D., of Saginaw, as state chairman.

George Anthony, M.D., of Flint, was re-elected as treasurer.

Paul T. Lahti, M.D., of Royal Oak, was chosen as a new member-at-large of the MDPAC Board of Directors.

During the meeting a handsome plaque was presented to W. C. C. Cole, Jr., M.D., Detroit, thanking him for his two years of service as the chairman. □

MICHIGAN MD DRAFT MAY TAKE 30 IN '68

The Michigan Selective Service reports that no final decision has been made yet about how many doctors will be drafted this year; but estimates have been made that place the figure at about 30.

About 1,100 physicians will be drafted from the United States in 1968. This is about half the number which were called in 1967.

In 1967, 59 Michigan doctors of medicine were commissioned, as well as 40 doctors of osteopathy.

Seminars Offered On Group Psychotherapy

The Wolverine State Group Psychotherapy Society, local affiliate of the American Group Psychotherapy Association, is holding a series of spring seminars in Ann Arbor and Detroit for members and interested professionals.

"Multi-transferences in Group Therapy" will be discussed by Max Sugar, M.D., New Orleans, Saturday, April 20, at 2:30 PM in the McGregor Memorial Conference Center at Wayne State University.

Milton M. Berger, M.D., New York, will speak on "The Flexible Use of Individual, Group, Family and Group Therapy" on Saturday, May 4, at 2:30 PM in Ann Arbor, at the Children's Psychiatric Hospital.

On Saturday, June 8, Hyman Spotnitz, M.D., New York, will lead the last seminar in the series at 2:30 PM, again at the McGregor Memorial Conference Center.

Cost of each seminar for non-member professionals is $2.00. Dinner will follow the meetings and spouses and friends of participants are welcome.

Reuven Bar-Levav, M.D., of Detroit, is president of the society; Stanley Woollams, M.D., of Ann Arbor, is president-elect. □

State Flying Physicians Help Direct F.P.A.

The Flying Physicians Association now has 69 members from Michigan with David C. Boyce, M.D., Grand Rapids, and William C. Van Gelder, M.D., Muskegon, serving on the Board of Directors.

Founded in 1954, the Association is constantly increasing its membership as more and more physicians take to the skies in their own airplanes.

The 2,000 members, who come from the USA, Canada, Puerto Rico, Australia, West Germany, West Indies, and the Republic of Congo, form a society of private pilots dedicated to the promotion of general aviation safety through example and teaching.

"We feel that we are a unique organization in that we are the only medical group specifically organized to promote aviation safety and also stimulate a medical interest in aviation among other physicians," says George Gumbert, M.D., of Lexington, Kentucky, president of the Association. "We are a completely self-supporting group with no financial aid from any governmental agency."

Doctor Boyce explains that, "The Association works closely with such groups as the F.A.A. and Air Traffic Control. Besides aviation information, our national meeting has become more and more involved in scientific medical presentation."

"We regularly sponsor group flights to various medical meetings, publish a monthly newsletter, and a quarterly called *The Flying Physician*," said Doctor Boyce.

Membership in the Association is open to all licensed physicians who are members of medical societies approved by the FPA Board of Directors, and who hold pilot certificates. In addition, membership is open to medical students, interns, and residents, as well as to any physician interested in aviation or aviation medicine even though he may not own a plane or fly.

Further information about the Association can be obtained from The Flying Physicians Association, Inc., 332 South Michigan Avenue, Chicago 60604.

Rheumatic Fever Study Started at U-M

Questionnaires are being mailed to selected internists, pediatricians, general practitioners, and local health officers by the "Michigan Rheumatic Fever Study" being conducted by the Maternal and Child Health Research Unit of the School of Public Health, University of Michigan, at 343 S. Main St., Ann Arbor.

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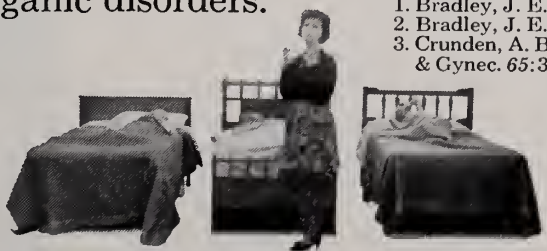
1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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1968 Clinic Day & Alumni Reunion May 15

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DETROIT

Registration Opens: 8 a.m.

The Wayne State University School of Medicine Alumni Association's Annual Clinic Day and Alumni Reunion Wednesday, May 15, in the Sheraton-Cadillac Hotel, Detroit, will be celebrated this year during the University's Centennial. It will be especially significant to medical alumni since the University's founding dates from the first classes held by the Detroit Medical College in 1868.

Beginning with 8 a.m. registration, events of the day will include five scientific programs during morning and afternoon sessions, the Association's annual meeting, and a complimentary luncheon.

Highlighting the annual Reunion Dinner-Dance will be class reunions and the presentation of Golden Anniversary diplomas to the Class of 1918.

Dr. Duncan J. McColl, class of 1893, who was born in the same year as the Medical School, will receive the Centennial Alumni Award.

Scholarship awards and other honors will also be presented, including Distinguished Service Citations to four medical alumni. They are Peter J. Talso, M.D., professor and chairman, department of medicine, Loyola-Stritch School of Medicine; Fred Harbert, M.D., chairman, department of otolaryngology, Jefferson Medical College; Edwin T. Nishimuru, M.D., chairman, department of pathology, University of Hawaii School of Medicine; and Jules H. Masserman, M.D., chairman, department of psychiatry, Northwestern University School of Medicine.

Alumni and other doctors of medicine are cordially invited to participate in the Clinic Day Program. Reservations for the clinical program and dinner dance may be made by writing Alumni House, Wayne State University, Detroit, Michigan 48202.

MARIO A. PETRINI, M.D.

ALUMNI ASSOCIATION PRESIDENT Mario A. Petrini, M.D., will be chairman of the morning session of the Scientific Program.

TOASTMASTER at the Reunion Banquet will be Jack Ryan, M.D., a 1955 graduate who is also a national collegiate debate champion. Dr. Ryan is a senior partner at the Memorial Clinic, Warren, Michigan and, among other affiliations, is a member of the Board of Governors of WSU Medical Alumni.

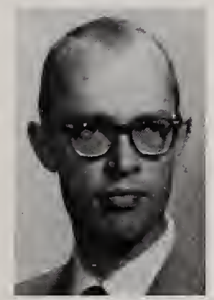
JACK RYAN, M.D.

ALUMNI CELEBRATE CENTENNIAL AT

SCIENTIFIC PROGRAM

MORNING SESSION

Clark Vincent, Ph.D.


Robert Coombs, Ph.D.

Peter Martin, M.D.

CLARK VINCENT, Ph.D.: "Human Sexuality — A Broad View." Dr. Vincent, who received his Ph.D. degree from the University of California at Berkeley, is director of the Behavioral Sciences Center and professor of sociology at the Bowman Gray School of Medicine.

ROBERT COOMBS, Ph.D.: "Acquired Sex Attitudes and Information — Role of Home and Parents." A graduate of Washington State University, where he received his Ph.D. degree, Dr. Coombs is an assistant professor of sociology, Behavioral Sciences Center, Bowman Gray School of Medicine.

PETER MARTIN, M.D.: "Changing Sexual Expectations in Women — The Special Role of the Physician's Wife." Dr. Martin, a 1942 graduate of Wayne State's School of Medicine, is clinical professor of psychiatry at WSU and the University of Michigan.

AFTERNOON SESSION

Harold I. Lief, M.D.

Richard H. Klemer, Ph.D.

RICHARD H. KLEMER, Ph.D.: "Marriage and Sexual Problems in Modern Society: An Overview of Pre-Marital and Marital Counselling." Clinical professor of family studies in the department of psychiatry at the Bowman Gray School of Medicine, Dr. Klemer is also professor and chairman of child development and family relations at the University of North Carolina at Greensboro.

HAROLD I. LIEF, M.D.: "Psychodynamics of Teaching Medical Students Sex Education." Director of the Division of Family Study of the department of psychiatry, University of Pennsylvania School of Medicine, Dr. Lief received his medical degree from New York University.

PANEL MEMBERS: Question-and-Answer Period.

MICHIGAN COUNCIL TO STUDY ABORTION FORMED RECENTLY

"Two years ago a public discussion of abortion would not have been easy to do. Today the climate is different," said Jack Stack, M.D., of Alma, at a news conference following the first official meeting of the Michigan Council for the Study of Abortion, Inc.

Aware that abortion is a complex matter requiring study and discussion from a number of viewpoints, the MCSA will conduct in depth studies and disseminate information in an effort to promote a climate of rational discussion in the context of accurate information about abortion.

"We want to make information available to professionals, organizations, and interested citizens," said Doctor Stack, who was elected a vice-president of the organization at its first meeting in Detroit on January 24.

"We strongly feel that we don't have all the answers to this problem," Doctor Stack continued. "We're going to conduct research and study, not lobbying."

The MCSA grew out of months of discussion which resulted in the consensus that little was known about the medical and legal problems relating to abortion and that there should be one group which could foster research and study in that area.

A decision was made to affiliate with the Association for the Study of Abortion, Inc., in New York. Persons from the State Health Department, Public Health Department, Michigan Human Resources Commission, the Florence Crittendon Home, the Michigan Women for the Medical Control of Abortion, the Michigan Council of Churches, the Protestant Episcopal Church, the Lutheran Church in America, the Michigan State Medical Society, and the Medical Schools at Wayne State, University of Michigan, and Michigan State, were involved in the decision to organize the MCSA.

MSMS representative to the Council is William H. Plesscher, M.D., of Lansing.

The organization will research questions such as: How many abortions are performed in the state of Michigan annually? Are all illegal abortions performed by non-medical personnel? How many hospitals in Michigan perform abortions? What is the opinion of the medical profession regarding abortion? For what reasons are abortions performed in accredited hospitals? What is the mental health effect of in-hospital medical abortions as opposed to back alley, underworld abortions?

Several Michigan physicians were elected to the Board of Directors of the organization. They are: Tommy Evans, M.D., professor and chairman of the department of obstetrics-gynecology at Wayne State University School of Medicine; William Goins, M.D., Director of the Detroit Maternal Infant Care Project; Ralph Rabinovitch, M.D., Director of the Hawthorn Center in Northville; Roy Smith, M.D., from the Bureau of Maternal and Child Health at the Michigan Department of Public Health; J. Robert Willson, M.D., chairman of the department of obstetrics-gynecology at the University of Michigan Medical School; and Rudolph A. Wyatt, M.D., obstetrics-gynecology representative of the Detroit Medical Society.

The organization will regularly publish a newsletter and results of studies. Members will also receive information from the national organization.

Further information on membership application may be obtained by writing the Michigan Council for the Study of Abortion (MCSA), 29575 Milton, Madison Heights, Michigan 48071. ☐

Marquette Ophthalmologist Back From Haiti Clinic

Harry Koenig, M.D., Ishpeming, spent the month of February in ophthalmological work at a clinic in Cayes, a depressed area on the south coast of Haiti.

The clinic at Cayes was established in 1963 by Focus, Inc., an Illinois non-profit corporation designed to give practicing American physicians an opportunity to represent their profession and country by working for a month, without payment, in needy areas overseas. Under the agreement with the Haitians, the volunteering physician pays his own flight transportation to Port au Prince, the capital, as well as hotel accommodations until he reaches his destination. The Haitians supply room and board and transportation in the clinic city, as well as a translator, ancillary personnel, and hospital beds.

Doctor Koenig did a great deal of surgery for bilateral mature cataracts and also saw many outpatients at the clinic in Cayes, which is about seven hours by jeep from Port au Prince.

Formerly chief of staff at Bell Memorial Hospital, Doctor Koenig is president-elect of the Marquette County Medical Society. ☐

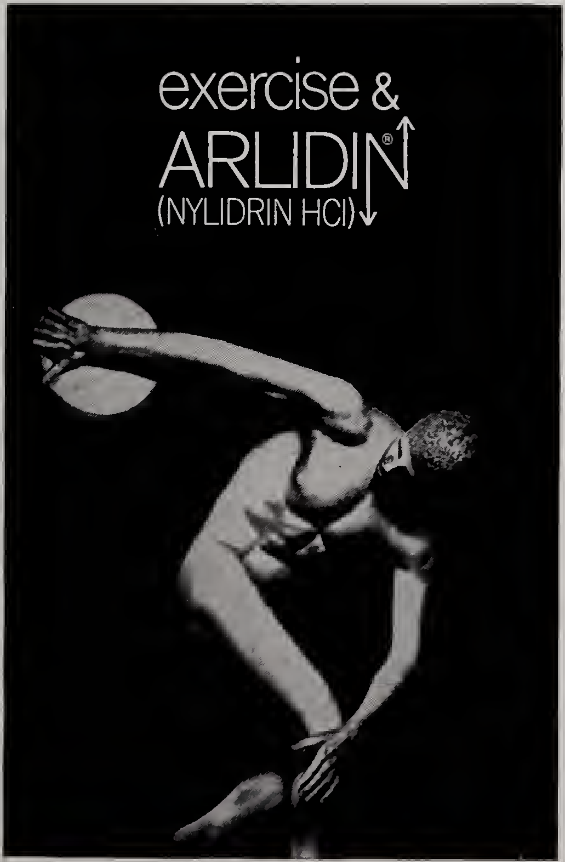
AMA, ASCP JOIN IN APPROVED PROGRAM FOR LAB ASSISTANTS

The AMA Council on Medical Education has established, in cooperation with the American Society of Clinical Pathologists, an approved program for certified laboratory assistants.

Upon completing an accredited 12-month course of hospital or laboratory school training and passing an examination, graduates are designated as certified laboratory assistants. To meet the increased demands for laboratory service, it is estimated that 100,000 certified laboratory assistants will be needed by 1975.

The current list of AMA-approved schools for laboratory assistants, as well as lists of other AMA-approved or accredited schools — cytotechnology, inhalation therapy technician, medical record librarian, medical record technician, medical technology, occupational therapy, physical therapy and x-ray technology — may be obtained by writing the AMA's Department of Allied Medical Professions and Services.

A six-page pamphlet, "A Career for You as a Certified Laboratory Assistant," may be obtained by writing the Secretary, Board of Certified Laboratory Assistants, 445 N. Lake Shore Drive, Chicago, Illinois 60611.



Goodsell to Lead U-M Medical Alumni

John O. Goodsell, III, M.D., of Saginaw, has been elected 1968 chairman of the University of Michigan Medical Center Alumni Society's board of governors.

He succeeds George W. Slagle, M.D., of Battle Creek.

MPH FELLOWSHIPS AVAILABLE AT U-M

A study program leading to a Master of Public Health degree, with emphasis on chronic disease, adult health, and aging, at the University of Michigan School of Public Health is now accepting applications for 1968-69.

The invitation to apply is extended to students with a B.A. or an advanced degree in the health field or social sciences.

For further information contact Ian T. Higgins, M.D., Program Advisor, Chronic Disease, Adult Health and Aging, The University of Michigan School of Public Health, Ann Arbor, Mich., 48104.

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Medical evaluation is an important first step toward rehabilitation; in programs of the National Society for Crippled Children and Adults. Doctors direct the work of Easter Seal therapists to help crippled and adults overcome their handicaps.

Urges County Societies To Take Advantage Of Michigan Week

"Michigan Week, to be held May 19-25, presents county medical societies with an opportunity to focus on a number of medical concerns," says Brock E. Brush, M.D., chairman of MSMS Public Relations Committee.

"For example," Doctor Brush said, "the theme for Saturday, May 25, is 'Our Youth.' A medical society could arrange with local high schools to invite selected students interested in the health profession for a workshop on the various careers in the health field. There are excellent films and printed material on this subject, and countless ways in which an educational and inspirational program could be set up for students."

"Livelihood Day" on Wednesday, May 22, or "Education Day" on May 23 are also possibilities, Doctor Brush said. "While the students are at school, a physician could give a talk on the opportunities and need for doctors today. I am sure many schools would cooperate in this."

"There are many ways in which county medical societies can take the initiative in Michigan Week, and the MSMS Public Relations Committee, which can be contacted through MSMS headquarters in Lansing, stands ready to help county societies in any way possible," Doctor Brush concluded.

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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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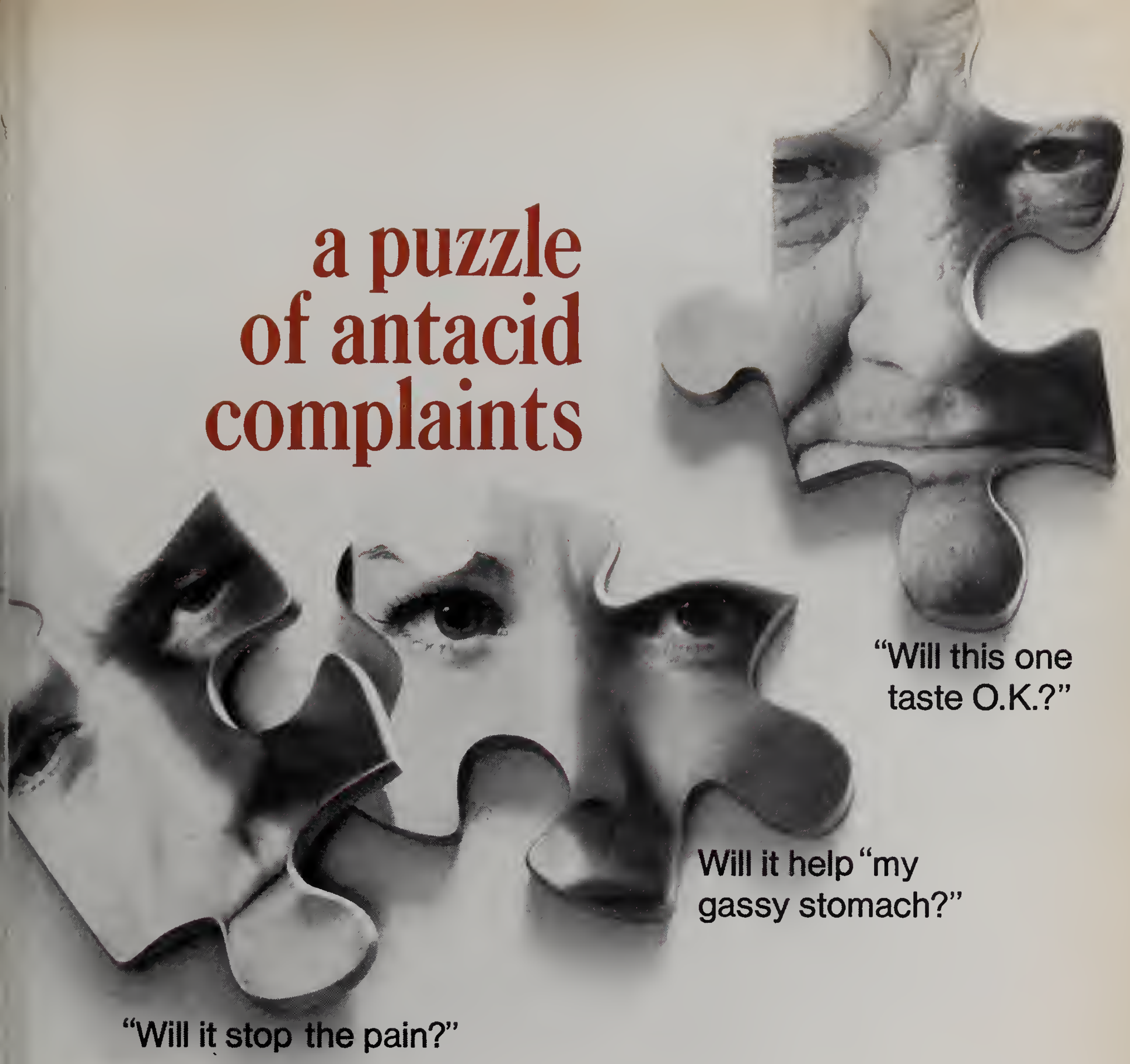
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Will it help "my
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References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I.E., Personal communication.

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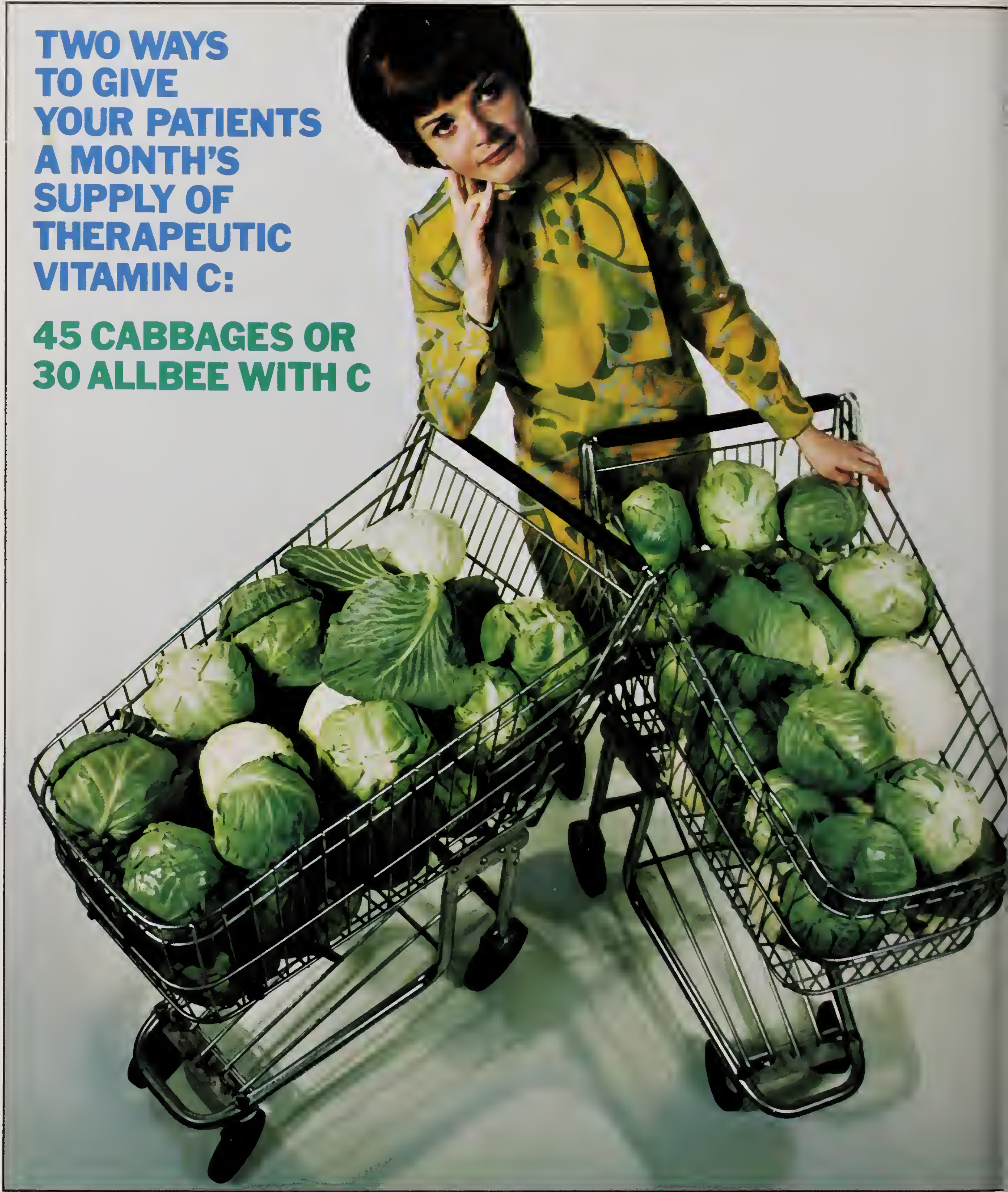
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BLUE SHIELD PRESIDENT ASKS:

How Common Is Our Cause?

The reality of the question before us is not the existence of Blue Shield but the extent, the shape, of that existence in the future of medicine in Michigan.

The reality is that in the year just passed, Michigan Blue Shield paid approximately $175,470,000 for well over six million claims involving more than twelve million services to the sick and injured among the more than 5,499,000 persons — more than half the population of the state — covered by its programs.

The reality is that most cautious business projections show that this year the payment figure will be more than $200,000,000 for more than seven million claims.

The reality is not those millions of people and dollars themselves but the *reasons* which placed those millions on, shall we say, the *ledgers of medicine,* under Michigan Blue Shield.

Those reasons distill to a *single, simple* one:

IT IS THIS:

The cause of private medicine in Michigan and the cause of Michigan Blue Shield is a common cause.

It always has been.

There is *nothing* in Blue Shield's future to change it.

When your colleagues first explored the idea of what was to become Blue Shield, in a meeting of the Michigan State Medical Society in Battle Creek in 1931, they had to overcome barriers set up in their ethical law to prevent their taking part in what might have become "an economic undertaking."

I could flossy-up this discussion with emotion about near-starvation in our land in those days, and about the incidence of diseases previously associated only with, say, the Ganges, but that would be pointless.

(Note: The following is a speech by John C. McCabe, President, Michigan Blue Shield, before a recent meeting of the Oakland County Medical Society. I personally believe the message deserves early printing for all the MSMS members to read. —Brooker L. Masters, M.D., Chairman, Publication Committee.)

The true point of reality is men of medicine saw that their cause needed what was to become Blue Shield.

The barriers were knocked down, one by one, not like the walls of Jericho in final triumphant blast and shout but in quiet and patient work.

The most essential part of that work assures that Blue Shield would not be a commercial enterprise, an "economic undertaking," but would be a means of service alone, with free choice of physician, with limitation of benefits to service, with exclusion of profit.

This took time. It took really until 1940 to implement the slowly developed plans. And it became apparent immediately that the concern for cause, the cause of medicine, as set forth in this new invention of Blue Shield, was far ahead of itself.

The first plan was to offer, in effect, comprehensive full prepaid medical care in home, in the physician's office, in hospital.

PLEASE REMEMBER this first goal. The goal was right. The know-how was not.

In little more than a year the program was $500,000 in debt and had a bank balance of $2,000. Benefits had to be reduced on a pro-rated 20 per cent basis. The struggle continued, and in June, 1942, the comprehensive part of the plan was shelved. Benefits were limited.

To condense this history, in 1944 doctors were repaid their withheld pro-rata funds. In 1945 the State Society was repaid the $10,000 — yes, $10,000 — which had been borrowed for original capital, plus $7,500 — yes, $7,500 — which had been borrowed in driblets in the worst times.

But in 1948 Michigan Blue Shield won a national award for being the first state plan to enroll a million members.

That was twenty years ago, painful as it may be for many of us here to add up the years. Many things have happened to Blue Shield since, but they total realities of growth in a common cause.

Not one branch, or twig, or leaf of that growth was put forth without the knowledge and guidance of Michigan medicine, acting through the representative and preponderant position which it

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CONTINUED: HOW COMMON?

has always had and has tonight on the Blue Shield Board of Directors.

Oh, there were troubles in those twenty years. There are some now.

In the M-75 program, which was a pioneer when it was first proposed, the nation's economy ran away from income fee levels. Fewer and fewer persons had their prepayments cover their total care. People said even their increased income did not leave enough to meet the differences between your fees and our schedules.

This is a past matter. We are discussing present reality and about the oneness of our cause. Permit me to continue with this immediacy in our minds.

As those troubles persisted, and as you and your patients became increasingly irked by these fixed fee levels and patient income classifications, by such things as slow recognition of specialties, by all the signs of what you might call obsolescence of what you and Michigan Blue Shield had devised, medicine and Shield went back to that original search for common effort for common cause.

In a year of intensive study, starting in July, 1966, a Blue Shield committee which was always preponderantly composed of physicians renewed this search and found what is in substance the Variable Fee and Extended Benefits Program we are beginning to implement now.

The search involved question and answer meetings with representative physicians and laymen throughout the state during the year, and free exchange of ideas. The committee, management and staff traveled many hundreds of miles and worked many hundreds of hours. The committee members cannot be too highly commended.

The program is not invention. It is not synthesized. It is a successful attempt to reflect appropriate equity with respect to both those who render service and those who pay for it.

THE CONCEPT OF reasonable, customary and prevailing fee was proposed in resolution Number 29 of the House of Delegates of the Michigan State Medical Society in its 1966 convention. The language of the Blue Shield concept is the exact language, to the comma, of the House.

The extended benefits part of the program puts in one package all of the improvements which Blue Shield had been able to add, in amending riders, to the M-75 program since inception, and extends days and types of care in all ways which medical experience and Blue Shield actuarial studies has shown possible and needed.

The home and office care part of the program, adds one essential weapon of medicine: to strike at disease early, when it may yet be weak and may be conquered, before it has ravaged man — the man who quite commonly does not seek your help until he is struck down, because he is insured only for catastrophe.

The prescription drug part of the program is also an essential arm in our mutual cause. I am sure that there is not a physician here who does not know, no matter how affluent his patients, that many a prescription goes unfilled because of cost, no matter on what other terms the patient may rationalize it to you and himself.

Do you doubt that money is the cause? In 1967, under Medicaid, Michigan Blue Shield paid more than 2,000 pharmacists for more than 1,500,000 prescriptions. Studies show that practically all prescriptions in this population, were filled.

But these are realities of the *future*, even if it is the immediate future. The reality now is the matter of your participation in the new program, and how that participation serves our cause.

I WOULD ASSUME that all of you here know the criteria of establishing what we call, under the new program, the Variable Fee. You have each received literature from us describing its development, and full discussions concerning it have appeared in many of your Bulletins and Journals and in the national medical press. Let me most briefly go over this criteria for establishing *reasonable charge levels.*

Your fee for any service will be paid in full, without regard to patient income, when it is your *customary* one for such service, when it falls within the *prevailing range* of fees charged for such service by your colleagues in your own general socio-economic environment.

Let me interject again here now the fact that these criteria came from no Blue Shield conference but came from your House of Delegates.

One immediate objection from some areas was that existing fee schedules would be used to establish the new ranges. This is not correct. The ranges being developed are using as a source your charges, not your Blue Shield payment.

A second objection was based upon the mistaken belief that ranges would be established by political community alone, or would be statewide, or would be established by various other means of distinction which would be manifestly unfair.

The truth is that ranges are being established based upon size of community or communities and such factors as area of state, in recognition of the exact differences in such fee determinants in the past.

A third objection came from an uneasy feeling that the idea of prevailing range meant that the

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physician at the lowest end of the range, let us say that kindly doctor beloved of Hollywood, whose standard fee for a heart transplant is a peck of potatoes, that this man's standard would drag down that of all of his colleagues.

The objection did not take into account the fact that each region of such establishment includes many, many hundreds of physicians, at least, and that the Kildares just mentioned are few.

It also ignored the other end of the graph, that which is inhabited by the higher charging physicians, and the fact that they influence the prevailing range as well.

A fourth apprehension was that this mechanism might evolve into another fixed fee schedule, freezing you in the ice of a formula which does not permit change. The truth is that a doctor may request change in customary fee upon 90 days notice, citing as reasons any of many factors.

Action will be immediate. It should be kept in mind that even should this request fall outside the prevailing range at that time and be disallowed beyond the extreme of range, the factor of the request itself will tend to extend the prevailing range, in standard statistical method.

BUT THIS BRINGS us to a *fifth* concern, *and one I share.* It is that the very flexibility of the program could, without self control, result in such fee escalation as to bring us all in grave danger of control by others.

You may have noticed the warning of a former president of the American Medical Association, Dr. James Z. Appel, in an address at the Philadelphia Medical Association the other day. Dr. Appel, as quoted by United Press International, said that "The voluntary establishment of reasonable income ceilings is the only protection the profession has against governmental price controls." He added that doctors must pass on to the patients some of the savings resulting from increased productivity, *especially as the amount of free service diminishes.*

He concluded, and I quote, "Unless something of this sort is done, society might well withdraw this freedom we enjoy to set our own fees and charges."

Walter J. Zimmerman, M.D., remarks in a recent issue of the Oakland County Medical Society *Bulletin,* there is some fear that the Variable Fee Program — and I quote — "is just another fee schedule in disguise."

Doctor Zimmerman continues:

"It could be just that, if it turns out that the rate at which fees are escalated outruns Blue Shield's ability to take in subscription cash. "However — and I continue to quote — "However, the plan is calculated to remain sound if it encounters only the normal evolution of fees for professional service.

"In any event, it looks to this writer," Dr. Zimmerman concludes, "as though we have everything to gain and nothing to lose by lending Blue Shield our participation and cooperation at this time, first because the Plan needs us to sell the new program, and second, because the doctor who signs the participating agreement can get out again on short notice if he finds himself disenchanted with the way the plan works out in his case."

The notice period is 15 days.

WE AT BLUE SHIELD are exploring utilization review procedures, partially in this regard, in cooperation with the profession both in Michigan and other states, and we shall report conclusions when possible. I do believe this concern should be kept in mind.

May I quickly add that I believe your experience with Blue Shield in present review procedures, both in connection with this and in the matter of determination of reasonableness of fee mentioned a few minutes ago, has shown you that we at Michigan Blue Shield *have* and intend *to continue to cooperate* fully with the profession in such matters.

Even during the confusion of the early months of Medicare, Michigan Blue Shield questioned few claims. We sent less than one percent of those claims question to Society review committees. We resolved the rest ourselves.

In our regular business we routinely review random samples of claims, as you know. Last year, in 1967, we paid a total of more than six million claims, as I noted.

Gentlemen, of those millions, a total of 990 went to State Society review committee. In percentage, that is .016 percent. And that is quite a batting average.

As I have said, we do not intend to force doctors to spend their time shuffling paper. Your business is rendering medical care.

We at Blue Shield are convinced that the new program will work and will advance our common cause as none of us foresaw, even a few years ago. There is a necessary *if* in that conviction, of course. The *if* is the matter of doctor participation.

IF DOCTORS PARTICIPATE, we shall succeed. *If* they do not, *we are in grave and common danger* — both Blue Shield *and* private medicine.

I can well understand why many doctors did not wish to participate in the M-75 program as it became antiquated. It forced physicians into additional billing of higher income patients. You and we suffered patient resentment, even though their certificates contracted them to this exact procedure, and even though Blue Shield made every attempt to educate both individual and group subscribers in every way.

I have not mentioned per-case participation which, as you know, presently permits a physician to retain the right to charge a greater amount in such cases as he may choose, provided he gets agreement from his patient.

This is an arrangement we now allow under the program which we have extended into our new program at the request of the State Society's Council. I would not be speaking with candor, however, if I did not indicate some serious misgivings about this.

I am afraid it may successfully deter full participation and will be looked upon by those in our community whom we must also satisfy — those who pay the bill — as an indication that the medical profession is unwilling to be cooperative, is unwilling to even subject itself to the administrative jurisdiction of an organization in which it plays a major role — in fact, the significant policy-making role.

THERE ARE OBJECTIONS which we hear periodically which are more philosophical in tone.

Put simply, it comes from physicians who object to any association of any kind with the so-called third party. They see no basic difference between government and the private payers of the bill for their services, nor any difference between commercial insurance companies and Blue Shield.

They feel that somehow their best interests are served if they remain aloof and apart from the matter of medical economics and allow it to be settled in some fashion between their patient and whoever it is that is paying his bill.

Can this kind of unwillingness to work with the system work to anyone's advantage?

Realistically, who can object? There are adequate provisions for payment outside range for unusual circumstances and procedures.

In addition, the classic and once wise justification for charging the affluent enough money to permit you to fulfill your proud duty of caring for the poor no longer holds.

In your general range of practice, the new Blue Shield Plan pays full fee with no connection in any way with patient income. In your treatment of the elderly and the indigent under government programs, you are entitled to customary fee, and the early inequities in those programs are being overcome.

WHY NOT PARTICIPATE? As I hope I have indicated, I find it hard to come up with a reason not to, except for the philosophical one I mentioned, and while I can respect and understand that, I cannot agree.

Let us look at this matter of participation in a positive sense, in terms of why you *should* participate.

In a purely selfish view, if you participate you are paid directly by Blue Shield with a minimum of paper work and with no collection problem — with, in fact, no financial contact with patient, even when you decide unusual circumstance merits additional fee.

Consider non-participation from an impersonal point of view. I have no doubt that should non-participation be large there will be inevitable and rapid escalation of fees, for such is the nature of economic pressures no matter how high may be our resolves.

Should such escalation occur, and occur in the measure which I think quite possible and in the measure toward which some elements of our society look with eager anticipation, Michigan Blue Shield and Michigan private medicine will be in true danger of losng all control of our drive toward our common goals, as I mentioned earlier.

I become as annoyed as all of you at this repeated waving of the flag of socialized medicine before us at the drop of a Medicaid aspirin, but tired as we may be of the warnings, they are true.

THE DANGER IS REAL.

The boy who is crying wolf at us all is not imagining or joking.

There are wolves abroad.

Or should I say, *at home*. Abroad, in every na-

Continued on Page 530

AUTHOR

John C. McCabe is president of Michigan Blue Shield, Detroit.

Sustained circulatory, respirator and cerebral stimulation for th

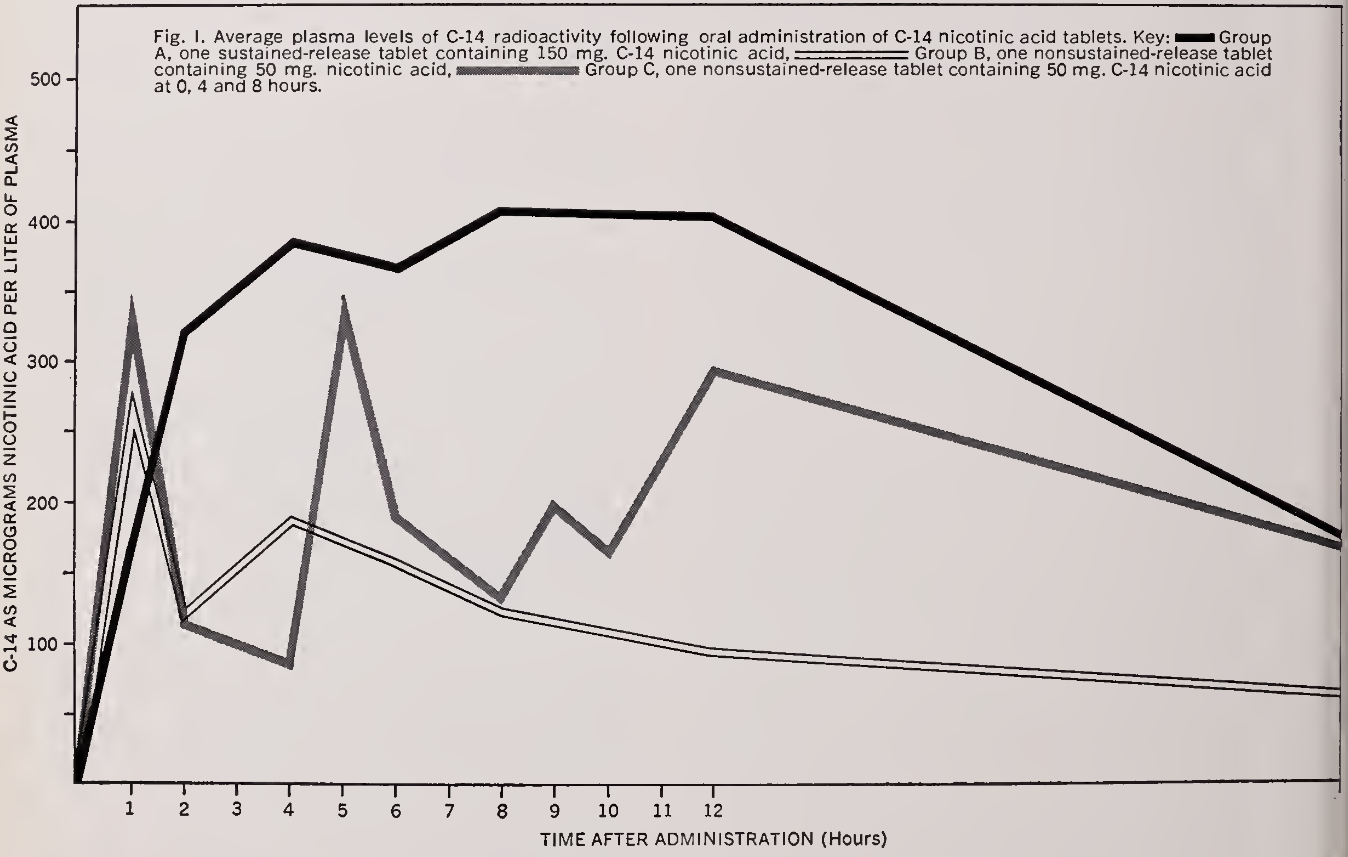

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazo TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Als cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more aler

ged and debilitated

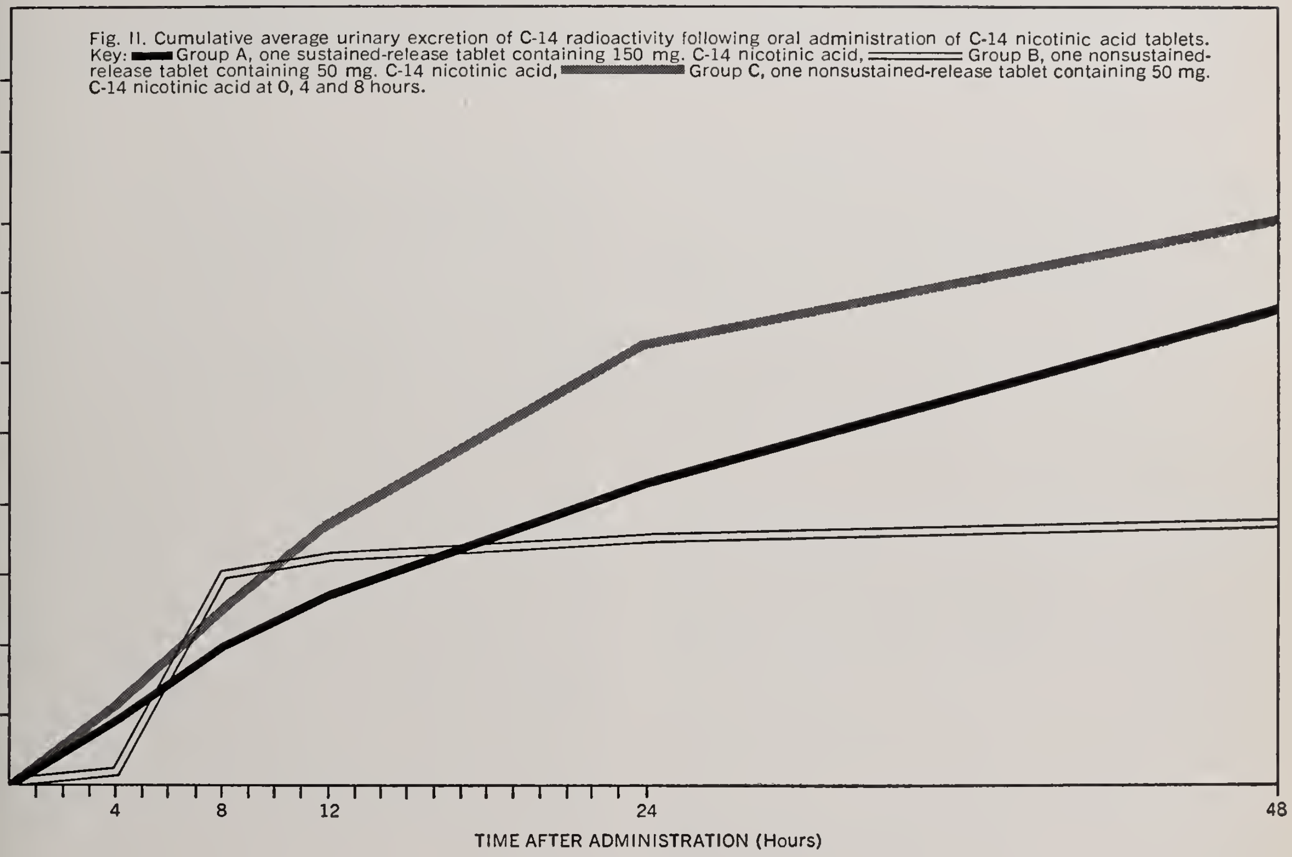

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ■ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory,
motional stability, social attention improve. Fatigue,
pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will
ermit your patients to enjoy the benefits of time-
rolonged nicotinic acid/pentylenetetrazol therapy,
t an economical price. Dosage is only one tablet every
2 hours.

ontraindications: There are no known contraindica-
ions.

recautions: Exercise caution when treating patients
ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

tion in Europe, the wolves took over some time ago.

I have discussed our common cause, about the goals that we should both have as targets. It seems to me that this can be crystallized very simply to provide a mechanism substantially which sustains and maintains the desirable elements of the private practice of medicine in such a way as to make available quality care at the lowest possible cost.

While that may sound like a trite statement of the type that indicates that I am for motherhood and against sin, please don't hear it that way.

It's that simple.

There are those who are convinced that a practical operational method is not obtainable. Certainly, if it is obtainable, it is going to occur through our structure and with your cooperation, as negative as that might seem as a raison détre for Blue Shield.

Blue Shield must be the answer.

THERE IS NO OTHER way that I can see.

Certainly, being against government or being against Blue Shield is not enough.

A positive policy must be put forth and I frankly think that none is more positive in the way of an available mechanism than Blue Shield.

As I see it, it is a simple question of working cooperatively and positively together in the development of the techniques needed to reach a common cause.

There are those who attack the efficiency of your care: there are many who cry thief and worse at the economics of that care.

I have been reading with interest the advertisements of some of our commercial competitors in the national magazines, in thinking of our own position as being one with medicine in common cause.

I note with wry gratification that more and more of these ads use Blue ink in their layouts, but I see them wandering farther and farther afield from all idea of service. Permit me to quote from one: This advertisement points out, in bold face italics, that payments under the policy, "go direct to you. Use the money for whatever you want, to pay back bills, to buy that vacation you owe yourself, or anything you desire." Then it says, "You do not have to give any of this money to a doctor or a hospital. It belongs to you."

True, this insurance is sold as a sickness income policy, but I do not think I need to go into its implications.

TO CONCLUDE, Blue Shield was created by physicians as a mechanism to serve the valid aspirations of both physicians and the public it serves. It has evolved according to these basic targets, sometimes falling behind, but always keeping to the original rules of service — as a structure operating without profit in the financial sense for the profit that comes as a result of the satisfaction for doing a job well. We have existed and continue to exist for you and the public, and the valid aspirations of each. Our cause is common, and it will continue to be.

In our view, our new program serves that common cause and merits your fully participating support. ☐

WORD WATCHING IS FUN IN MEDICAL JOURNALS . . .

Richard L. Reece, M.D., Hartford, Conn., gave an unusual address on "Does Humor Have a Place in Scientific Writing?" at the 1967 convention of the American Medical Writers Association. The following excerpt drew many smiles:

"Word watching is a good way of drawing fun-seeking readers into expository flow. At one time or another, most of us have poked fun at medical names or terms. It's safe, it's harmless, and it helps relieve frustrations over long, latinized words.

"To illustrate word watching, I have an article from the *Journal of the American Medical Association*. Its author, Doctor Howard H. Steel, an orthopedic surgeon, is wrestling with the problem of naming toe nail and fingernail lesions which resemble Garlic-Cloves. He has already discarded the term Steel's Nails because it lacks modesty, and he has rejected Hyperkeratotic Polypoid Ungual Fibroma as stark and inhumane. Here he is leading up to his final name—Garlic-Clove Fibroma.

"What is needed is a warm, homey sort of name. Numerous precedents exist for the use of a familiar descriptive term, a comparison with some household object . . . the silverfork deformity; the funnel breast; nutmeg liver; oat cell carcinoma; scalloped ribs; cauliflower ear; portwine stains; the doughnut pessary sage spleen; currant-jelly stool . . . coffee ground vomitus; and bringing up the rear, the grapes of wrath of the proctologist.

"The author's intent is clear. He wants to entertain his reader by playing on the shapes and sounds and meaning of names. Whatever his intent, I think he succeeds, for articles like his are likely to be read."

(The complete address by Doctor Reece appears in the November-December 1967 issue of the *American Medical Writers Association Bulletin*.)

Views Expressed on Recommendation Of State Crime Commission

Many physicians will want to study in detail the ramifications of a recommendation about the alcoholic made by the Michigan Commission on Crime, Delinquency and Criminal Administration. The following recommendation is quoted directly from the Commission's Digest of Recommendations:

Manage the Chronic Alcoholic Outside the Criminal Law

The Michigan Commission on Crime believes it is appropriate to continue to apprehend and detain publicly intoxicated persons who endanger others, under provisions of the criminal code. But, for him who endangers himself, a new statute is called for to authorize civil protective custody of not more than 48 hours. We urge the establishment of small emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community.

Michigan Medicine invited members of the MSMS Committee on Alcohol and Drug Dependence to comment on one of the recent recommendations of the Governor's Commission on Crime, Delinquency and Criminal Administration. Comments are invited from all MSMS members for the Mailbag Department of the April issue.

The Commission recently presented the report of its year-long study, and offered 25 recommendations.

The first of the following letters to the Commission recommendation re "Manage the Chronic Alcoholic Outside the Criminal Law" is from the Chairman of the MSMS Committee on Alcohol and Drug Dependence, followed by other comments from Committee members:

HERBERT A. RASKINS, M.D.
DETROIT

May I speak wearing a multi-cornered hat: (1) Member of the Crime Commission; (2) Chairman, MSMS Committee on Alcohol and Drug Dependence; (3) Member, MSMS Committee on Mental Health; (4) Member, AMA Committee on Alcoholism and Drug Dependence; (5) Member, Detroit Mayor's Committee on Rehabilitation of Drug Addicts.

While it is true that the Crime Commission, so far, has made recommendations regarding the medical implications of caring for the alcohol dependent person, many other aspects of its function are going to also have consequential medical implications; viz., concept of criminal responsibility and its relations to psychiatry; civil commitment in lieu of prosecution and subsequent medical care programs for alcohol and drug dependent persons; medical care of sexual deviates who stand in violation of the law; probation and conditional discharges and medical-psychiatric care programs.

Obviously, each of these items becomes multiply subdivided.

OUR VARIOUS MSMS Committees must remain alert to each of them especially as the Legislature begins to consider the proposed revision of the Michigan Criminal Code.

The Michigan Commission on Crime, Criminal Administration and Juvenile Delinquency, among many other considerations, has spent much time reviewing the proposed criminal code revisions. The topic to which you make reference, "Manage the Chronic Alcoholic Outside the Criminal Law," relates directly to the proposed revision. It constitutes recognition by law, judiciary, law enforcement and, hopefully, legislature that the "chronic alcoholic," alcohol dependent person, is a sick person. His alcoholism is an illness and the person suffering from this illness is a responsibility of the physician and the entire medical profession conpled with the ancillary help of many of the other "care-providing" professions.

The entire aim of the recommendation of the Crime Commission is to provide the alcohol intoxicated and/or dependent person with the high quality of medical care to which he is as entitled as any other ill person. This implies the provision of adequate and total medical care.

In the position paper adopted by the Crime Commission at its meeting of December 15-16, 1967 was included the following statement:

"Chronic public intoxication is the disease of alcoholism in a most visible form. No cure of alcoholism will result from imprisonment for a violation of the public intoxication statute, but the proposed § 5545 and a civil 'detainer' statute will legitimate the police officer's taking the individual into custody. From that point forward, the relinquishing of heavy usage of alcohol is a matter between the individual himself and the resources of clinical medicine and community service which, acting in concert, would terminate the individual's dependence upon alcohol."

WE ALL CAN very quickly perceive the complete naivete of believing that the provision of detoxification shelters throughout the community constitutes the answer to the problem of alcoholism. It does, however, provide a very specific, medically supervised facility to which the law enforcement officer can turn when he encounters the acutely alcoholic person. Once the alcoholic is in the detoxification shelter he is no longer a police problem but now is a medical responsibility and it becomes a matter of medical decision as to what treatment programming then ensues. It can immediately deal with whatever medical or psychiatric, or both, emergency exists, effectuating disposition as clinically indicated.

What follows after this screening function in the provision of general medical, psychiatric and sociologic care now becomes the focus of Medicine and the community. How are we to determine exactly what are the needs of this particular person and what services exist within the community to provide for them? This also constitutes essentially a medical responsibility. Whether we view this as an administrative function of Public Health or Mental Health is really beside the point because both offices are going to be intimately involved in properly servicing the alcohol dependent person, the alcoholic.

Proper hospital care, medical and surgical and psychiatric must be provided; outpatient medical and psychiatric clinic facilities will be required; aftercare units to deal with all the various ramifications of social rehabilitation and utilization of the multitude of social agencies, governmental and voluntary, and community organizations will be essential to the proper medical care of this person. We as physicians have a vital role to play in this kind of treatment and care program.

On January 10, 1968 the MSMS Committee on Alcohol and Drug Dependence voted unanimously to accept and support the provisions of the proposed revision of the Michigan Criminal Code as it relates to problems of alcoholism. As per this date, MSMS Council has not acted on this recommendation. It is our aim to follow through on this recommendation toward the provision within the state of Michigan of adequate medical and rehabilitative facilities to meet with the individual and community problem of alcoholism.

DONALD L. DAMSTRA, M.D.
BRIGHTON

The recommendation sounds like the Michigan Crime Commission is grabbing a two-edged sword and better be very careful about how they grab hold of it. This recommendation certainly indicates that they are recognizing the need for medical treatment for intoxicated persons. I see no reason to suspect that the intoxicated persons needs any more or less medical treatment regardless of whether he has endangered himself, or has endangered someone else, and has been detained under the provisions of the criminal code.

IF SUCH A recommendation were to be adopted into law, it would seem to me that it would be encumbent upon all of the jails, who have occasion to hold people under the criminal code, to provide adequate medical treatment.

Providing for forty-eight hours of protective custody for the purpose of emergency detoxification would certainly be for many intoxicated persons better than no help at all. On the other hand, such a facility available generally would allow many seriously ill alcoholics to continue drinking, recognizing that any time they wanted to they could place themselves in protective custody for treatment. This type of treatment with such a limited scope certainly may not only be not helpful but actually hinder the recovery of a significant number of alcoholics. These are factors that would certainly need to be taken into consideration before such a change in the law could be enacted.

ANOTHER QUESTION which should certainly be asked is "Why is it necessary to establish small emergency detoxification shelters with medical facilities which is, for practical purposes, creating new medical facilities when such a function should much more logically be carried out in the local general hospitals?"

Creating new facilities for a specific and specialized medical problem is always a significantly more expensive proposition than mobilizing and utilizing existing medical facilites.

RICHARD C. BATES, M.D.
LANSING

The suggested change in the criminal code sounds great. I'm all for it.

CLAYTON K. STROUP, M.D.
FLINT

There are two parts to the report of the Michigan Commission on Crime. In the first part, they state "they believe that it is appropriate to continue to apprehend and detain publicly intoxicated persons who endanger others, under provisions of the criminal code."

I BELIEVE THAT this is contrary to the opinion that alcoholism is a disease. However, we who believe alcoholism is a disease and should be treated as a disease are in a position in some cases to actually give a person who is an alcoholic a license to commit a crime. This can no more be accepted than a person with the diagnosis of kleptomania being given a license to steal. Therefore, people who become intoxicated and endanger others must have some sort of penalty attached to their misconduct, but in addition, if we are to be of any service in the prevention of further crime or further danger to other people, something must be done in the way of treatment of the alcoholic. Therefore, if the person who becomes intoxicated and endangers others is to be placed in some type of a security complex, there must be medical treatment to prevent the recurrence of their misconduct.

The second part of the report states, and I quote, "But for him who endangers himself, a new statute is called for to authorize civil protective custody of not more than 48 hours. We urge the establishment of small emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community."

AGAIN, I AM IN disagreement. I think that the day is coming when all hospitals must have an alcoholism treatment unit. It would be my hope that there would be a security area with intensive nursing care as needed for the severely ill alcoholic, but in addition to this, there should be a unit which might well be used by other ambulatory patients which might be called a self-service unit, one where the patient made his own bed, stood in line to get his meals, and did not require very much nursing care.

The second part of this requirement would be that each hospital would have an alcoholism treatment program. I feel that each hospital should have alcoholism therapists and consultants in the care of the alcoholic.

In some hospitals, this might be entirely within the structure of the hospital and the consultants be from the attending staff, but in others it might be conceivable that alcoholism therapists could organize in groups, either profit or nonprofit, in which they would lease their services in the treatment of alcoholics to the smaller hospitals.

THERE SHOULD ALSO be out-patient departments which the alcoholic should be required to attend. This should not be at the tax payer's expense. The alcoholic should pay his own way and the only distinction between the care of the alcoholic and patients with other diseases would be the mandatory therapy.

We in the medical profession have a "tiger by the tail." We have advocated the proposition that alcoholism is a disease and at this point we have been trying to find methods of care for the alcoholic. To date we do not have a cure. There have been too few hospitals which will admit the alcoholic patient and the refusal of the others to take care of alcoholics has put an unfair burden on these few hospitals. I believe the same thing might be said of physicians. There are too few physicians who will treat alcoholics and the refusal of the other practitioners to assume their responsibility has made an unfair burden on these few doctors.

C. FRED MOENCH, M.D., M.P.H.
MIDLAND

The Michigan Commission on Crime recommendation re "Manage the Chronic Alcoholic Outside the Criminal Code" as submitted in its Report to the Governor appears to have some serious medical implications as well as socio-economic involving the individual, the home, the community, and the tax dollar.

Having had considerable experience in dealing with the problems created by the alcoholic and his medical and socio-economic treatment, I agree with the Michigan Commission on Crime that it

Continued on Page 536

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of childbearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories **Philadelphia, Pa.**

Weighing on his mind, too

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, non-narcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.

is appropriate to continue to apprehend and detain publicly intoxicated persons who endanger others, under provisions of the criminal code.

HOWEVER, FOR THE alcoholic who endangers himself, the new statute called for authorizing civil protective custody of not more than 48 hours and the recommendation for the establishment of small emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community, presents many complexities in terms of definition of alcoholism as a disease, protection of civil rights, methods and procedures for the apprehension of the alcoholic who endangers himself only, and techniques of enforcement. These are factors requiring careful consideration and thought before a new statute offering civil protective custody could be considered practical for enforcement.

In the first place, all intoxicated persons apprehended are not alcoholics in terms of our present definitions. An intoxicated person may be a social drinker who has misjudged his threshold of tolerance for alcohol. A true alcoholic is oftentimes a lone drinker who successfully conceals his illness from his family, his doctor, his minister, and his business associates for years. It is only when the eventual change in drinking pattern permits a diagnosis through physical, mental, and emotional signs and symptoms that we may suspect the person as being an alcoholic.

IF WE ASSUME that alcoholism is an illness it should be classified and subject to treatment as are diseases with signs and symptoms of cancer, diabetes, heart disease, tuberculosis, etc. The uncontrolled diabetic who refuses treatment endangers himself and might become a menace to the public while driving his automobile on the highway. The proposed new statute to provide protective custody and detoxification for the alcoholic raises a question of whether or not this kind of statute should not be broadened to include all illnesses.

Another question involves a definition of the intoxicated person who endangers only himself — it is doubtful whether such a person exists. In my experience an intoxicated person is either a potential or a direct hazard to others. Primarily, by direct physical injury; secondarily, through threats to the socio-economic security of others. Under the proposed new statute, who would be responsible for making these decisions?

IT IS MY FEELING that the proposed 48-hour civil protective custody order is far too short a time to accomplish emergency detoxification. Along with detoxification is the necessity for certain laboratory and X-ray examinations to establish an uncomplicated diagnosis of alcoholism or intoxication. Entirely absent in the proposed statute is any provision for education of the intoxicated or alcoholic person which is a most important factor in treatment. It is also possible that the 48-hour protective custody would encourage persons inclined to become intoxicated to abuse this civil type of treatment knowing full well that they would not be confined in jail. The protective custody order for emergency detoxification would require that 24-hour coverage from the prosecutor's office would be necessary to obtain the order. This has not proved too difficult in obtaining protective custody orders for alcoholics involved under criminal law. Some plan of procedure would have to be devised to deal with the chronic alcoholic outside the criminal law.

In a constructive vein, I do agree in principle that emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community should be available. These services should be available to all alcoholics regardless of their status with aspects of criminal law. In fact, this type of treatment facility is a primary need throughout Michigan. I believe that treatment of the alcoholic must be provided in general hospitals of each community regardless of whether or not the suitable medical services are administered by the public health or mental health programs. I believe that the period of treatment must include education to the patient about alcohol and alcoholism and that the length of treatment should not be less than ten days to two weeks, with adequate follow-up supervision of patients through Alcoholics Anonymous, the public health department or the mental health program, once the patient is discharged from the hospital, and that careful attention be paid to the patient's need for habilitation and rehabilitation. I believe that the "team approach" utilizing local treatment resources and facilities is essential to obtain optimum results.

THE PROGRAM FOR treatment of the alcoholic, devised and administered by the State Board of Alcoholism as it was formerly known, but currently placed in the Michigan Department of Public Health, made a fine beginning with their limited resources in providing treatment for the alcoholic and progress has been made. I believe it is now timely to consider the initiation of treatment facilities in general hospitals, similar to that developed in St. Luke's Hospital in Saginaw.

I believe that the doctors of Michigan owe a debt of gratitude to the Michigan Commission on Crime for the splendid effort made by that commission in concentrating on the need for study and planning toward the objective of obtaining adequate treatment facilities and services for the chronic alcoholic.

HAROLD M. GAY, M.D.
COLEMAN

With the first statement it is difficult to see how anyone could disagree. It is basic to our form of government that that government shall protect our liberty from the licence of the few.

I also see no possible quarrel with the recommendation that a drunk should be protected from his own folly. Putting an inebriate under protective custody may very well save his life. Properly administered, and we cannot even discuss it unless we can assume that there would be responsible administration, this provision is really nothing more than enlightened Public Health.

AS USUAL THE CRUX of the whole matter rests not on what needs to be done or how it should be done or even on achieving a consensus which will provide that the thing shall be ordered done. The real hurdle it seems to me is assembling those things necessary to implement and to accomplish the goal before us.

Buildings are easy to get. So is equipment. Ancillary medical personnel are relatively easy to assemble.

BUT WHAT OF THE administrator? He should be a physician. In fact, in my opinion, such a clinic or "Shelter" will fail under anything but medical management. Just let one diabetic or stroke victim die in such a place unattended by a physician and the whole thing will collapse. Such management will be extremely difficult to attract. Such a physician will be handling drunks — alcoholic or otherwise — and the attitude of the average physician in private practice in relation to drunks is too well known to deserve or need further comment.

However, Russia, I understand, is doing something very similar to this, indeed better than this. Their program is aimed at final arrest of the disease in those who are determined to be alcoholics. What Russia can do certainly Americans can do too. This kind of program has been a serious need for thousands of years. In our highly organized, complex society it is no longer a need it is a must.

Even recognizing what at present seem to be almost impossible obstacles I none-the-less wholly agree with the Commission's report and recommendations.

JOSE J. LLINAS, M.D.
LANSING

I entirely agree with the philosophy implicit in the report.

The real problem, however, is whether our local communities and the people of the State are ready to assume the responsibility for this type of care.

It is stated policy of the Michigan State Department of Mental Health that no direct programs for alcoholics will be funded under Act 54 of 1963, (the Community Mental Health Services Act). This in fact precludes any cooperative arrangements between local hospitals and mental health boards for the development of detoxification centers and other appropriate services.

It seems clear to us that the legislature should act to decide who will have responsibility for these programs, and how they should be carried out and funded.

To fight TB-
find it first!

Make tuberculin testing routine
with every physical examination.

TUBERCULIN,TINE TEST
(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

PUBLIC RELATIONS

MICHIGAN NEWSPAPERS COMMENT ON MEDICAL SCENE

A challenge to the medical profession to police itself effectively is presented in an editorial from the Muskegon *Chronicle.* Entitled, "A Few Bad Apples Are Spoiling Luster of the Doctor's License," the editorial discussed the operation of state board of registration in the nation. The closing paragraph declared:

"A medical license represents a high trust which the lay public is prone to respect. It behooves the profession to insure that the charlatans in their midst never destroy that faith."

The many western Michigan readers of the *Grand Rapids Press* recently read an editorial praising the Kent County Medical Society. The editorial rated a KCMS project as significant. The article lauded the project for "helping to provide Grand Rapids with more effective service from policemen, firemen and deputies."

The editorial, in part, declared:

"Working with recruits and in-service veterans who are interested, KCMS Project Chairman Mark Vasu's team of 10 physicians and surgeons trains policemen, firemen and deputies in proper emergency procedures and techniques.

"The medical project had its origin, explains Doctor Vasu, in the doctors' criticism of procedures used by policemen and firemen in emergencies. 'It finally,' he says, 'became a matter of why criticize why not help?' "

Grand Rapids Police Supt. William A. Johnson has praised the physicians for "giving so freely of themselves to make our police force a better instrument of community service."

The *St. Joseph Herald-Press* recently declared:

"There is something very special about a good doctor. In these days when so much emphasis is put on the common man and equality, the instinct of survival dictates that when we get sick, we want no part of the common man. We want an uncommonly good doctor and good doctors are not created overnight.

in the treatment of
IMPOTENCE
Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

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Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
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Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

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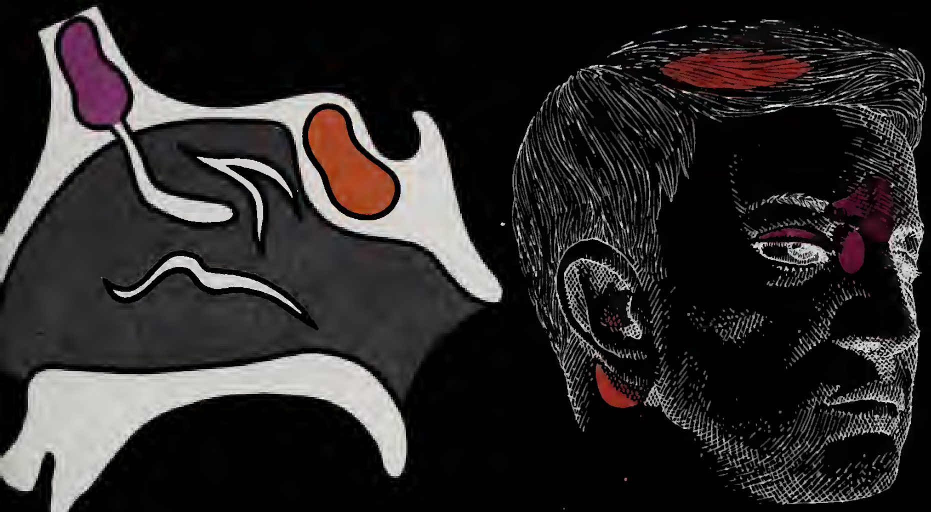
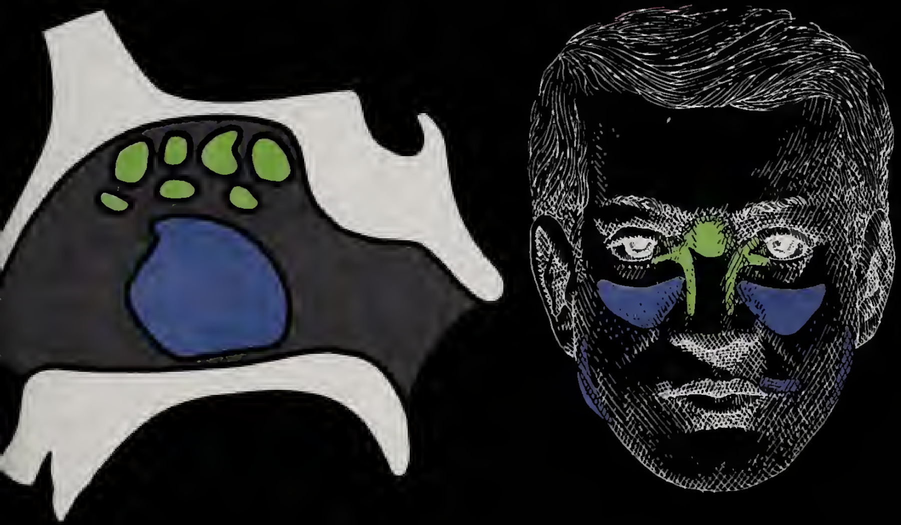
INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Sources of sinus headache

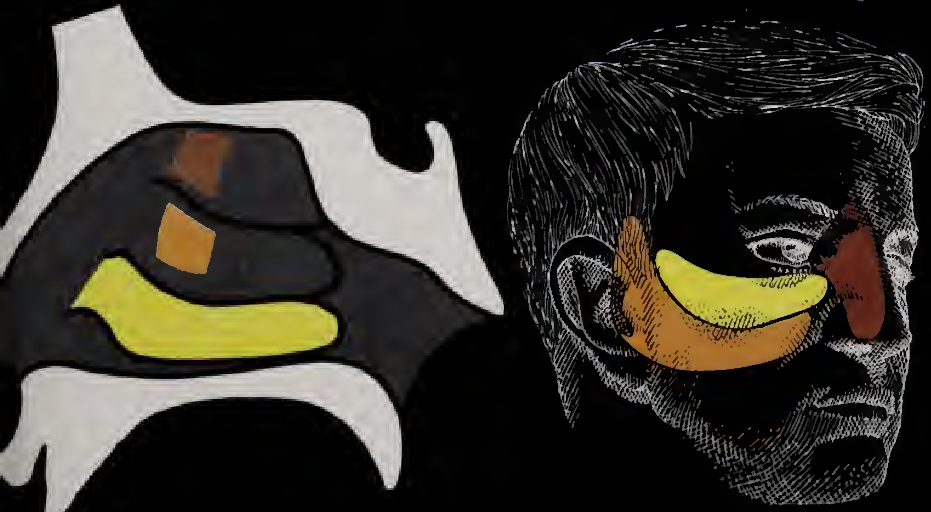


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

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Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

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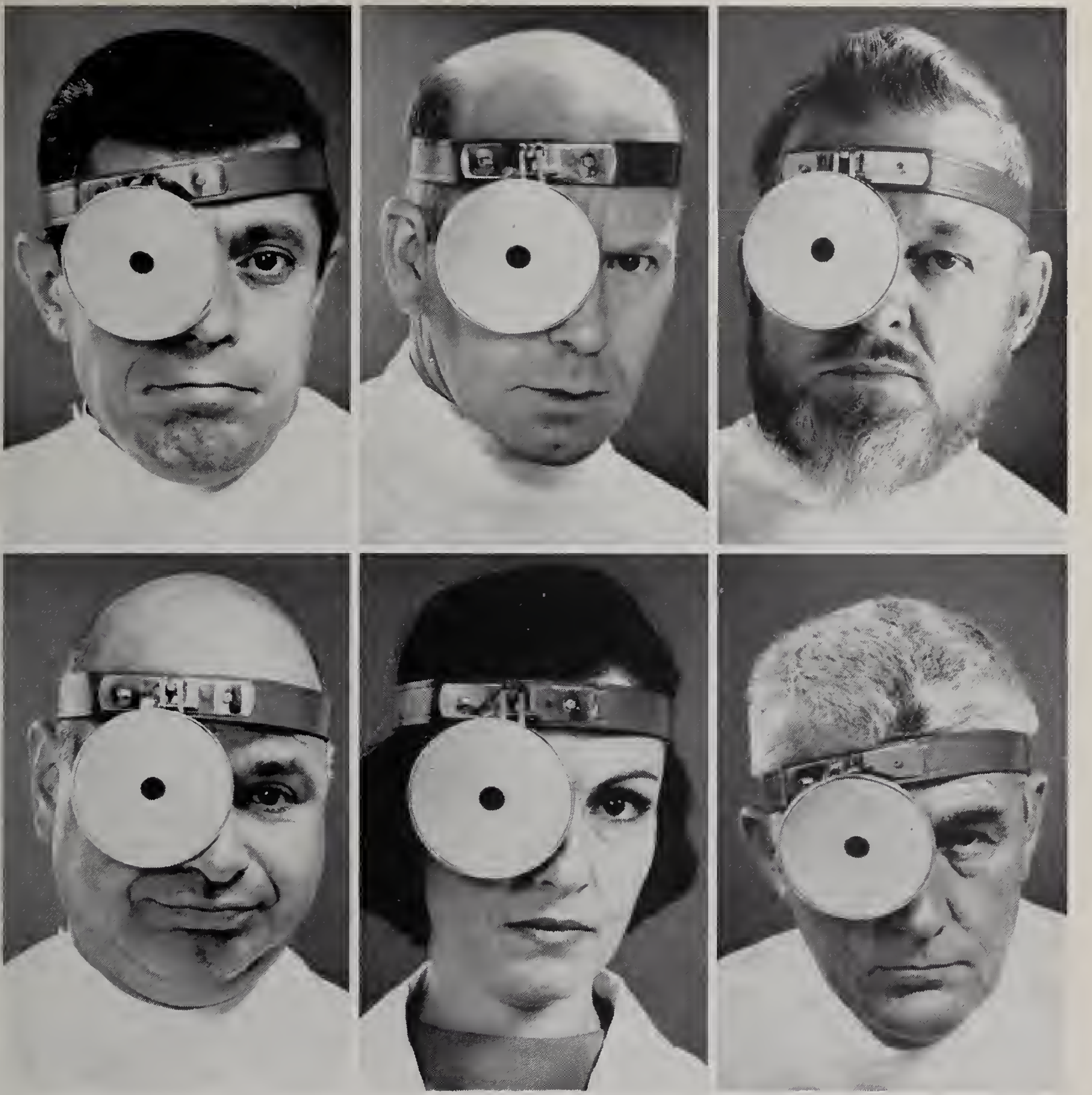
S-IN-81-4C

W|C WARNER-CHILCOTT Morris Plains, N.J.



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

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when you want to provide the combined benefits of two accepted agents in the treatment of mild to moderate hypertension. **(Contraindications: history of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.)**

when you want to prescribe therapy that is generally well tolerated.
(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. **(One tablet a day usually costs about a dime.)**

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Arsenio B. Ablao, M.D., Northville State Hospital, Northville, 48167

John E. Boudeman, M.D., St. Joseph Mercy Hosp., Ann Arbor, 48104

Carter D. Brooks, M.D., Upjohn Company, Kalamazoo, 49001

Jerome E. Feldstein, M.D., 3601 West 13 Mile Road, Royal Oak, 48072

Donald V. Jablonski, M.D., Detroit General Hospital, Detroit, 48226

Allan M. Katz, M.D., 461 West Huron St., Pontiac General Hospital, Pontiac, 48053

Charles T. Kelso, M.D., 18371 North Shore Estates, Spring Lake, 49456

Bernard M. McGibbon, M.D., 900 Woodward Ave., St. Joseph Mercy Hosp., Pontiac, 48053

Carl Morton, M.D., 3601 West 13 Mile Road, Wm. Beaumont Hosp., Royal Oak, 48072

Ervin Novak, M.D., Upjohn Company, Kalamazoo, 49001

Paul B. Simmons, M.D., 461 West Huron St., Pontiac General Hosp., Pontiac, 48053

John C. Wells, Jr., M.D., 1220 Lakeshore Drive, Muskegon, 49441

Fredk. M. Adams, M.D., 800 S. Adams, Birmingham 48011

Manoochehr, Agah, M.D., 1151 Taylor, Detroit 48202

Severo R. Armada, Jr., M.D., 32900 Five Mile Road, Livonia 48154

Manou C. Atash, M.D., 1728 Grant, Birmingham 48009

Lutfi Y. Bayazit, M.D., Mt. Pleasant State Home, Mt. Pleasant 48858

Rajendra Kumar Bhama, M.D.. Ypsilanti State Hosp., Ypsilanti 48197

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James F. Clark, M.D., 201 Lafayette Ave., S.E., Grand Rapids 49503

Gerald F. Conway, M.D., 938 David Whitney Bldg., Detroit 48226

Edward F. Crippen, M.D., 316 City-County Bldg., Detroit 48226

Pedro Ruiz DeCastilla, M.D., 424 Quincy Street, Hancock 49930

Harvey M. Gendler, M.D., 269 Northland Drive, Rockford 49341

Phillip A. Hoskins, M.D., St. Joseph Mercy Hosp., Ann Arbor 48104

Robert H. Moyad, M.D., 303 Pearl Street, Ypsilanti 48197

Satya Paul Pasricha, M.D., Ypsilanti State Hospital, Ypsilanti 48197

Cornelis Van Nuis, M.D., 245 State Street, S.E., Grand Rapids 49502

Robert Wylin, M.D., Harper Hospital, Detroit 48201

James W. Sharpe, M.D., 310 E. Water St., Port Huron 48060

Arthur R. Basel, M.D., 901 Crescent, Midland 48640

B. B. Kumar, M.D., Mt. Pleasant State Home, Mt. Pleasant 48858

Antimo Candell, M.D., 2318 Medford, Ann Arbor 48104

James E. Baker, M.D., VA Hospital, Battle Creek 49016

Wm. Henderson, D.O., 320 W. Superior St., Alma 48801

Alan L. Keaton, M.D., 2410 Walter Drive, Ann Arbor 48103

Norman N. Komar, M.D., 1605 Argyle Crescent, Ann Arbor 48103

Robert R. Ross, M.D., Detroit General Hospital, Detroit 48226

Gary S. Sandall, M.D., 611 Church Street, Ann Arbor 48104

Lyall C. Stilp, II, M.D., 1525 Marion, Ann Arbor 48103

Earl E. Sunderhause, M.D., 1086 Island Drive, Ann Arbor 48104

MANY REPRINTS ORDERED

Pfizer Company ordered 100,000 reprints of an article by Doctors Peter Barlow and John H. Burger on "A Combined Drug for Asthmatic Symptoms," which appeared in the October, 1967 issue of *Michigan Medicine*.

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MAILBAG

I want to thank you for the excellent January issue of the *Michigan Medicine*. We are all extremely pleased that you dedicated this to Wayne State University on the occasion of its 100th Anniversary celebration.

Your articles were all good, interesting; and I thought the format of the entire presentation was one of the best that I have ever seen. Again, thanks to you and the State Society for this recognition.

Gordon H. Scott, Vice President
for Medical School Development
Wayne State University

Congratulations on the excellent feature in the February issue of *Michigan Medicine*, spotlighting the work of the Michigan physicians who have worked among the civilians of South Vietnam.

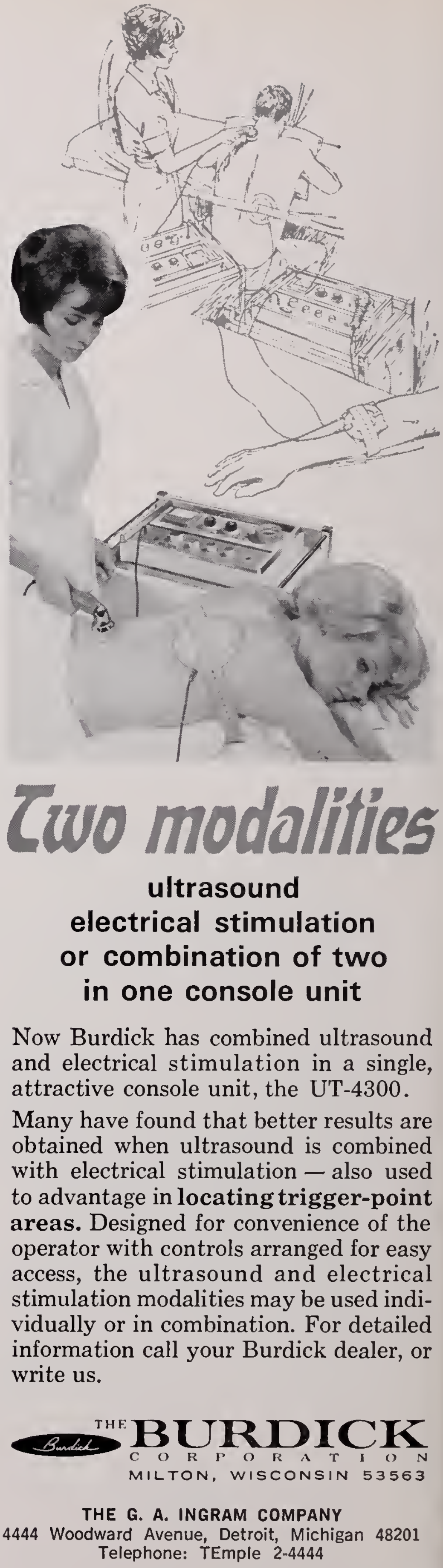
This past year, the International Health Committee of the Michigan State Medical Society took a survey of all county medical societies to ascertain how many physicians had served overseas in various programs. The total is well over 80 doctors. Many of these men have gone several times to the same country or different countries such as Doctors Alfred Swanson, John Rawlings, and myself.

I feel that the article and attractive cover, expressed the MSMS and AMA appreciation to all the Michigan men who have served overseas.

On behalf of the International Health Committee of MSMS I would like to commend those physicians.

Medicine speaks the international language of people and there is a tremendous medical need in all the developing countries. The physician who works overseas will use every ounce of energy and medical skill which he possesses to help people who desperately need him. The demands are rigorous, the appreciation of the people is real and heartfelt, and the satisfaction of the physician is genuine.

I hope the Vietnam feature will encourage other Michigan physicians to consider the possibility of some kind of overseas service. There are a wide variety of overseas programs which will sponsor a doctor who wants to work overseas, depending on



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the country in which he wants to work, length of stay, and the kind of work he would like to do.

Information on these programs can be obtained from the International Health Committee, P.O. Box 152, East Lansing 48823.

It would be appreciated if anyone knowing doctors who have served (and plan to serve) to please write in and let us know the name, date, and countries that they have served in and whether it was a missionary hospital, AMA program, clinical program, orthopedic overseas program, Project Hope, or other type of program. This will help us keep aware of what Michigan doctors are doing in the international field.

Hira E. Branch, M.D.
Chairman, International Health Committee

On behalf of the Wayne State University Centennial Commission I would like to commend you on the outstanding January issue of *Michigan Medicine* saluting the University's 100th year.

The issue has brought many favorable comments from both faculty and administrators at the University. We are pleased and proud to have been so well represented in such a highly regarded professional publication.

We at the University are hopeful that you and your reader audience will be able to join us in the many events planned during Wayne State's Centennial Year Observance.

Sincerely,
George E. Gullen, Jr.
Vice President
University Relations
Co-chairman Centennial Commission

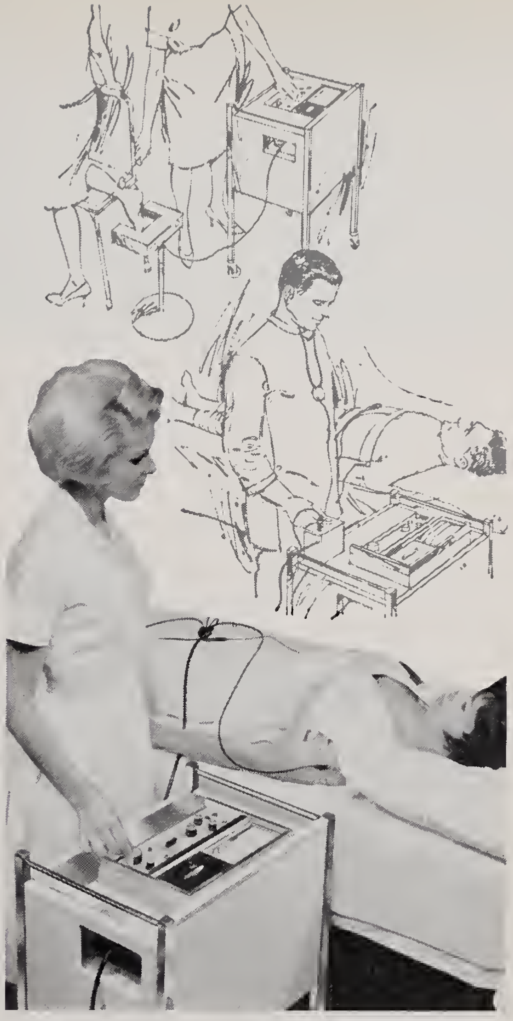
Congratulations! The January 1968 issue of *Michigan Medicine* is superb.

The photographs and art work add a great deal to the text. I like especially the picture of the old St. Mary's Hospital surgical amphitheatre. This was the center of clinical teaching and was an important factor in the renaissance of medical knowledge in Detroit in the 1880s.

I know the effort and work which goes into the production of a special issue of the State Journal and I wish to thank you and your associates.

As a member of the Wayne State University Centennial Commission I express the gratitude of the University for the special volume which will remind doctors throughout the State that Wayne is a state University which is training more students of Michigan than any other university.

Alfred H. Whittaker, M.D.
Detroit, Trustee,
W.S.U. Board of Governors



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IN MEMORIAM

I. W. Brown, M.D., Kalamazoo

Irmel W. Brown, M.D., a former director of the Kalamazoo Public Health and Welfare Department, died February 17. He was 73.

After receiving his B.A. from Albion College, he worked with Dow Chemical Company in Midland and in 1919 was appointed to the chemistry faculty at Albion College. He was graduated from the University of Michigan Medical School in 1925 and served his internship at St. Mary's Hospital in Grand Rapids in 1925-26.

Doctor Brown began practice in Marion and in 1928, he moved to Kalamazoo where he served as the city's health and welfare director from 1936 to 1942. Returning to private practice, he was on the medical and teaching staffs of Bronson and Borgess hospitals. He headed the Department of General Practice at Borgess in 1955.

He was a Life Member of the Michigan State Medical Society and a member of the International Society of Medical Health Officers and the American Public Health Association.

H. E. Carnes, M.D., Detroit

Harry E. Carnes, M.D., Detroit, died January 28. He was 59.

Born at Alabama City, Alabama, he attended Emory University, Atlanta, Georgia, and was graduated from the Emory University School of Medicine in 1939.

His internship was done at Ford Hospital from 1939-40. Shortly afterwards, he joined Parke, Davis and Company, where he did clinical investigation and industrial research for many years. He also served as editor of the Parke-Davis publication *Therapeutic Notes*. He held a teaching appointment as clinical instructor, Department of Medicine, Baylor University, Houston, Texas.

During World War II, Doctor Carnes served in the U.S. Army Medical Corps, 8th Medical Laboratory, in Australia, New Guinea and the Dutch Indies, attaining the rank of Lieutenant-Colonel.

He was a member of the American Society of Clinical Pathologists, the Federal Society for Clinical Research, and Theta Kappa Psi.

C. D. Eaton, M.D., Detroit

Crosby D. Eaton, M.D., Detroit internist, died January 27 at the age of 72.

He received the B.S. degree from Kalamazoo College and was graduated from the University of Michigan School of Medicine in 1922. After his internship at Grace Hospital in 1922-23, he began practice in Detroit, specializing in internal medicine and endocrinology.

Doctor Eaton was a Life Member of the Michigan State Medical Society and a member of the Michigan Diabetes Association and the American Diabetes Association. He was a member of the Detroit Boat Club.

Dwight Goodrich, M.D., Traverse City

Dwight Goodrich, M.D., retired Traverse City physician, died January 21 at the age of 83.

Doctor Goodrich was a past president of the Grand Traverse-Leelanau-Benzie County Medical Society.

Doctor Goodrich, born in Belize (British Honduras), was a graduate of Ann Arbor High School, Ferris State College and Wayne State University Medical School, class of 1917.

He began practice at Flint where he was a member of staff at Hurley Hospital. He received four years of postgraduate training in urology there. From 1932 until his retirement, he maintained a general practice in Traverse City where he was affiliated with the Munson Medical Center.

William Klein, M.D., Detroit

William Klein, M.D., Detroit general practitioner, died December 9 at the age of 65.

Born in Rumania, Doctor Klein received his premedical education at Northwestern University. He was graduated from the Detroit College of Medicine and Surgery in 1933. He served his internship at William J. Seymour Hospital, Eloise, and did postgraduate work at the Chicago Maternity Center.

In 1934, Doctor Klein began general practice in Detroit, affiliating with Brent General Hospital. He was Director of Villa Zion Geriatric Hospital in 1958.

He was a member of the Maimonides Society and American Geriatric Society.

Charles T. Lewis, M.D., Detroit

Charles T. Lewis, M.D., Detroit physician since 1920, died January 2 at the age of 75.

Doctor Lewis, born in Ontario, Canada, received his M.D. degree from the University of Toronto School of Medicine in 1916. During World War I he served as a Captain in the Canadian Army Medical Corps and was decorated with the Military Cross. He then served his internship at Harper Hospital and residency at Children's and Herman Kiefer Hospitals in Detroit and established his practice there.

He was a Life Member of the Michigan State Medical Society.

C. K. Stulik, M.D., Union Pier

Charles K. Stulik, M.D., Union Pier, emeritus associate clinical professor of pediatrics of the University of Illinois Medical School, died February 1. He was 78.

Doctor Stulik, who received his B.S. degree from the University of Chicago, earned degrees in pharmacy and pharmaceutical chemistry from the University of Illinois before entering medical school. He was graduated from Rush Medical College in 1916 and served in the U.S. Army Medical Corps during World War I.

In many years of practice in Chicago, he taught pediatrics at Rush Medical College, served as supervisor of infant welfare of Chicago for 25 years, was attending physician in pediatrics at Cook County Hospital for 22 years and consulting physician to many other hospitals and orphanages.

After moving to Union Pier 15 years ago, Doctor Stulik continued his practice of pediatrics and also served as deputy medical examiner of Berrien County.

Doctor Stulik was a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics and the Institute of Medicine. He was also a member of the Illinois Society of Medical Research and a Life Member of MSMS.

A collector of bells and antiques, he was a Life Member of the Art Institute of Chicago and an Associate Life Member of the Chicago Museum.

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is desirable.

See last page
for contraindications, precautions
and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication—or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

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* 1904 - 1967

SAYS MICHIGAN LAGGING IN SUPPORT OF HIGHER EDUCATION

BY ELMER WHITE,
EXECUTIVE SECRETARY,
MICHIGAN PRESS ASSOCIATION

Support for higher education is falling far behind other states a U-M study shows. Michigan appropriations to colleges and universities compared with appropriations of other states indicate a steady decline in this state's position since 1959.

On a per-capita basis, Michigan ranked 9th in 1959 with an expenditure of $12.33. In 1967 it ranked 17th. Appropriations per $1,000 of personal income put Michigan in 19th place in 1959. The state dropped to 27th place in 1967. Per-student appropriations in 1959 showed Michigan in 14th position. In 1967 it ranked 34th.

Taking all states into consideration, the average percent increase to higher education amounts to 214% since 1959; Michigan shows an increase of 142%.

* * *

Effects of not keeping up with increased costs is evident in rising tuition. Since 1959 enrollment has increased 126.5%, prices, salaries and wages have increased 48.3% and total operating costs have gone up 235.9%.

Michigan apparently is placing much less emphasis on aid to higher education than is the case in other states. □

MSMS Urges Editors Help Fight Quackery

MSMS placed an ad on the back cover of the 104-page Centennial issue of *Michigan Publisher,* the journal of the Michigan Press Association.

Copy described MSMS concern about quackery and urged editors to join MSMS in protecting the public health.

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Coffee Table Medicine

BY WALTER C. BORNEMEIER, M.D.
SPEAKER, AMA HOUSE OF DELEGATES

Statements are occassionally made, particularly in newspapers or magazines, that medicine is run by a hierarchy. Nothing could be farther from the truth.

Almost every doctor works at least part time to support some medical organization. The 200,000 physicians of the United States have a tremendous organization. This organization, however, starts at the grass-roots level.

THE COUNTY SOCIETY is the most important, for the county society is the crystallization of the ideas that start at the hospital coffee table. Almost every one who is active at the county level sits in on hospital staff, hospital doctor's room, and coffee table sessions. Certainly all actively participating state society people are the same people who are active in the county societies.

It follows then that the men who make the policy decisions at AMA level are the same individuals who are active at state level, county level and coffee table level.

The House of Delegates of the AMA is as grass roots as a town meeting. Its members are the fellows who practice medicine fifty weeks of the year and attend the AMA meeting the other two weeks. These practicing physicians make the policy. All new proposals are placed before reference committees for open hearings. There, any member of the AMA can discuss the proposals. Voting is limited to House of Delegates members.

A DOCTOR'S ATTENDANCE record at his local society meeting is not a true index of the man's interest in organized medicine.

Also, it is not an index of his scientific interest.

WHAT THEN IS A measure of the interest or support that the doctor gives to a unified profession? Among the many physicians who have contributed much to the health and welfare of the nation are individuals who seldom attend local society meetings. Some participate not at all.

It is difficult to find a common demoninator of interest. Certainly those doctors who attend their county or branch society meeting and work on committees have demonstrated concrete evidence of support. What about the man who never having attended a meeting of his local society is found suddenly to be the important officer in the society of internal medicine, or president of a foreign language medical group, or president of his hospital staff, or nominated for appointment to the AMA Council on Drugs?

Are not these people also giving their time and talent to create a better image of the profession?

Certainly we need a healthy nucleus of interested people to carry on the business affairs of our organizations, but most important we need all the rest of the members to support our organizations financially and be depended upon to swing into action if, as, and when they are needed. These non-attenders frequently pretend to be disinterested, yet they pay dues and provide the broad base from which the American Medical Association operates. These non-attenders are the reserves.

All of us together are Organized Medicine.

The ideas expressed at the Coffee Table may be the subject of a resolution at the next meeting of the AMA House of Delegates. With a broad base such as this, organized medicine can remain strong and can continue to serve the public in a manner befitting a noble profession. □

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MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 9
MAY 1968

AMONG THE IMPORTANT ARTICLES:

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SMOKING-HEALTH FEATURE

A four-page layout about the Michigan Council on Smoking and Health begins on Page 679. Physicians are urged to use the special order blank to obtain educational materials.

ABOUT THE COVER

The cover photograph this month is a typical scenic view of Michigan as attention is focused on Michigan Week, May 19-25. Please read the President's Message by B. M. Harris, M.D., this month for more information about the 1968 Week. The photograph, looking out over sand dunes toward Lake Michigan, was taken by Managing Editor Herb Auer north of Muskegon.

The sketch on page 599 was done by Craig Dennis, a senior at Lansing Eastern High School who hopes to become a medical illustrator.

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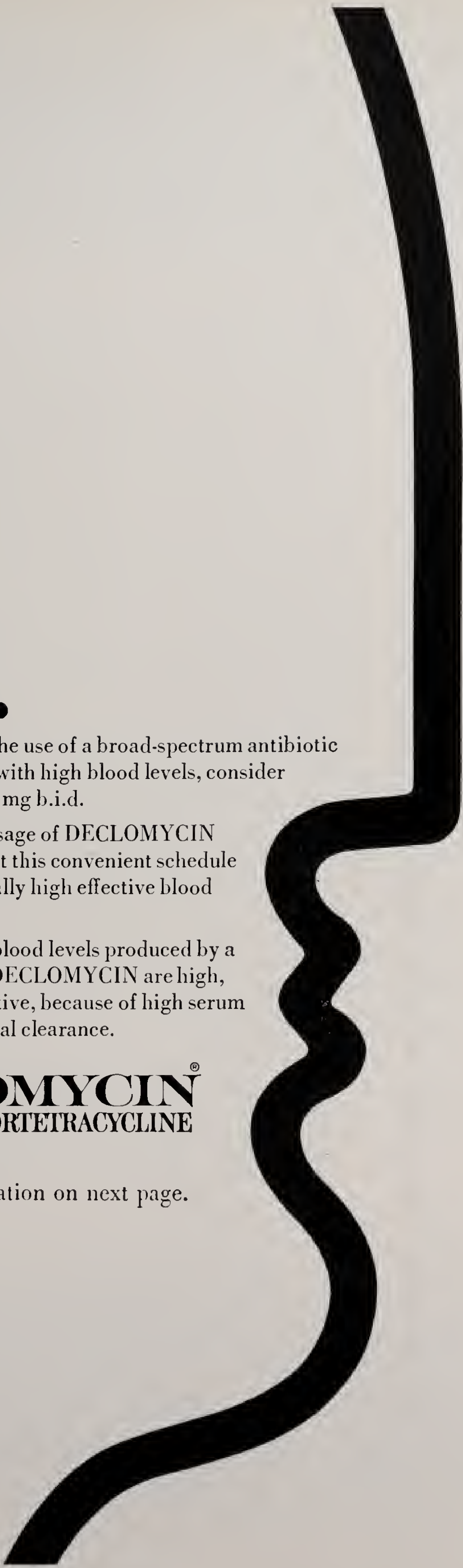

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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

"Michigan Week 1968" is celebrated during May 19-25. This is a project of the Greater Michigan Foundation in which all sorts of people participate. Good results seem to accrue to Michigan.

The board of governors of the Greater Michigan Foundation consists of 90 men who represent business, education and labor. Their President is Dale I. Sellers of Detroit. The purpose of the Foundation is to conduct volunteer programs for Michigan's progress, but most of its activities are built around the annual Michigan Week in the spring. Don Weeks is Executive Director and Win Schuler of Marshall is General Chairman of the 1968 Michigan Week. The MSMS Executive Director, Hugh W. Brenneman, is the perennial Chairman of the Professions Committee of the Michigan Week.

THIS WEEK COMES at a most fortunate time and the subject, "Michigan—Land of Hospitality" is especially apropos. There are tremendous social, economic, political, and human forces at work in the state. The extent to which we are successful in dealing imaginatively and progressively with these forces will determine the future of our state.

While the truth that "only a lawful society can build a better society"* is self-evident to the thoughtful, it must be equally true that harmony with the spirit of the law is as essential as adherence to the letter of the law in a progressive society.

How is that harmony engendered? Michigan Week has one answer. It uses the stimulant, the pep talk, the showmanship, the sales approach. And let it not be said that this approach is unimportant because it sells, and sales are necessary to remind us of our objectives and to present those objectives persuasively to others. But no matter how good the hoop-la, it must be followed up on the other 51 weeks of the year with solid evidence—actions proving that the advertising is legitimate, not phony. The masters of Michigan Week are the first to agree with this.

BUT IT IS ONE thing to call for friendly acts and quite another thing to program and carry them out.

The evincing of friendliness on an organizational basis is not quite so simple. People ignore weak organizations and fear strong ones. How often do they feel friendly toward the inanimate things called associations? The answer lies in the ability of the association to demonstrate its concern for the public interest and for people as individuals. What has your county medical society done to demonstrate its concern for your community's welfare *this week?* What project has your medical group carried out on an organized basis to demonstrate its desire for friendly intercourse with other segments of your community?

THE ABOVE THOUGHTS are not offered as preachments but rather as suggestions to which I take the liberty of adding a final one. Your county medical society woman's auxiliaries must be constantly reassured that you need them. They can be great assets. Just as the doctor's wife is his hospitality councilor and aide, so the woman's auxiliary can be the hospitality councilor and aide to the county medical society and they will be if they are asked.

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*Theme of Law Day U.S.A. 1968

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

Thoughts about the Cost Of Medical Education

BY DON MARSHALL, M.D.,
COUNCILOR, KALAMAZOO

Modern society needs physicians. Physicians have to be educated for their work. Who should pay for this education? The same questions could be asked for teachers, engineers, etc.

Under the free enterprise system of the past, a man desiring to acquire medical training received it by meeting academic requirements and paying tuition. An embryo engineer did the same, as did other professionals. Personal preference determined which vocation a youth entered. Supply and demand, and his own ability, largely determined his later success.

When the supply fails to meet adequately the demands of society what should be done? If there aren't enough physicians or nurses or physicists or teachers is anyone responsible for increasing the supply? Is each profession responsible, or are universities, or is Congress, as the executive of society?

AND WHO SHALL pay the cost?

In most advanced countries the world over the wealthy have been able to obtain whatever kind and degree of education desired, provided they demonstrated adequate intellectual capacity and ambition. In most free-enterprise countries it has been more difficult, and sometimes impossible, for the poor to do the same, because of their poverty.

In recent decades an increasing flow of private and federal loans, grants and scholarships has partly obliterated this differential. In fact, students in many science fields have had much of their education subsidized. Only more recently has it become a fact that no established medical student need leave school for financial reasons.

IF THE ABLE BUT financially-poor student is subsidized in order that society may benefit from his ability or genius, and if other students are subsidized because society needs them as trained professionals, has the aided student obligated himself to his benefactors, or is he still free and independent? If a medical school accepts large sums from state and federal governments, does it thereby abandon its academic freedom and become a prostitute of the legislature?

The National Health Manpower Commission has urged federal loans to medical students "to cover the full costs of tuition and living expenses during formal professional education." The AMA has replied that this would not necessarily increase the number of applicants or change the number coming from poor families. The AMA does agree with the need for more direct support of the educational functions of medical schools.

U.S. MEDICAL SCHOOLS in 1966-67 had a total enrollment of 33,423. Loans were made to 54.6% of these students, and scholarships granted to 22.7%. The loans totalled $18,773,992 and the scholarship funds $6,379,320. Loans and scholarships each increased in dollar value over the previous year. While in this past year 55% of all medical students borrowed money to continue their education, only 11% did it nine years earlier. Last year 23% of students were awarded scholarships, averaging $800 each. Nine years earlier the figures were 10% and $512. Probably some students fall in both categories. The amount of funds borrowed by medical students from government sources is rising while that from private funds is falling.

Medical schools are now approaching an annual total expenditure of a billion dollars. This includes both regular and sponsored programs. 54% of the expenditures now are from federal funds, nearly all of it for research and sponsored programs.

MEDICAL STUDENTS and medical schools face today a problem common to many aspects of our life: How can we afford all that we need plus all that we want without incurring complete socialization and federal control? How can we afford both butter and guns? How can we afford both to double our educational facilities and wipe out our ghettos?

A practical answer is that we can not afford not to do so. It will be far cheaper to rebuild our slums than to handle guerilla warfare. It will be cheaper to educate more members of the health team than endure the drop in health and morale that would otherwise ensue. And in the process the private sector of our people must constantly realize that, generally, government steps only into vacuums, and does not enter those aspects of our

Continued on 574

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CONTINUED: VIEWPOINTS

life where private enterprise is doing a job that satisfies the public.

SO YOU AND I, the medical profession, all professions, the public, private business and foundations, together must do all we can to support medical students and medical schools, to support education, to support slum clearance and the removal of the sores in our society.

This will take priorities. The money that today goes into tobacco, alcohol and cosmetics would be a great help if spent in better directions. Farm and oil subsidies and many other government handouts should be cut back to a more logical size, or abolished. We who live in luxury should give up a fair share of it to meet the needs of society, and not leave the job to Congress.

Medical education ideally should be paid for by the students so far as he is able, by private loans and philanthropy from there on, and only when there is no alternative by government subsidy, both state and federal. Since the average citizen is loath to give away his earnings, government by taxation forces him to contribute his share. Trying then to spend it wisely, Congress puts strings on the pocketbook. If private giving were widespread and generous enough, the administrative overhead cost and the restrictions imposed from Washington could be avoided. □

Smoking-Health Council Offers Materials, Page 679

BY BROOKER L. MASTERS, M.D.,
CHAIRMAN, PUBLICATION COMMITTEE

Over the past several years many physicians, recognizing the health hazards of cigarette smoking, have taken it upon themselves to discourage the habit by stopping smoking, and in so doing, setting an example for their patients and the public-at-large.

Michigan physicians are concerned about cigarette smoking and many have taken it upon themselves to participate in programs and committees to educate youth and adults about smoking and its relationship to health and disease. One way in which physicians are active, and heard, is through Michigan State Medical Society's mem-

Continued on 576

ANNUAL MEETING OF THE MUSCLE SYMPOSIUM

Auditorium of Wayne County Medical Society

Wednesday, May 22, 1968 — 9 a.m. to 5 p.m.

Sponsored by: **Muscular Dystrophy Associations of America, Inc., Metropolitan Chapter, Department of Neurology, Wayne State University School of Medicine. Detroit-Macomb Hospitals Association.**

Speakers: Dr. Ade Milhorat, Medical Director of the Institute of Muscle Disease, New York City.
"Recent Advances and Diagnosis of Treatment of Muscle Disease"
Dr. Paul Vignos, Case Western Reserve University, Cleveland
"Diagnosis of Muscle Tone, Weakness and Atrophy"
Dr. George Koepke, University of Michigan, Ann Arbor, Michigan
"Rehabilitation aspects of Muscle and Nerve Disease"
Dr. Harry Ingberg, Wayne State University—Detroit, Michigan
"Electro-Diagnostic Procedures"
Dr. Erwin Siegel, University of Illinois, Chicago
"Neurosurgical concepts and the Management of Contractures in Musculo-skeleto Disability"
Dr. John Stirling Meyer and staff will present **"Neurological Aspects"**

For Reservations, Contact:
M. K. Newman, M.D., Chairman of Muscle Symposium
16861 Wyoming Avenue, Detroit, Michigan 48221

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bership in the Michigan Council on Smoking and Health.

Michigan Medicine, in cooperation with the Publicity and Public Relations Committee of the Michigan Council on Smoking and Health, has prepared four special pages, 679-682, containing the most recent information on smoking; activities of the Council; and a listing of publications for physicians and patients which are available in quantity from the Council through the fine cooperation of its member agencies.

We hope each physician will review the information and request copies for his use, and for placement in his waiting room for patients to read and take with them. ☐

Books Received for Review

Sensorineural Hearing Processes and Disorders. Edited by A. Bruce Graham. 559 pp. Illustrated. $19.00. Little, Brown and Company, Boston, Massachusetts, 1967.

Diabetes Mellitus: Diagnosis and Treatment, Volume II. Edited by George J. Hamwi and T. S. Danowski. 250 pp. $2.50. American Diabetes Association, Inc., New York, 1967 ☐

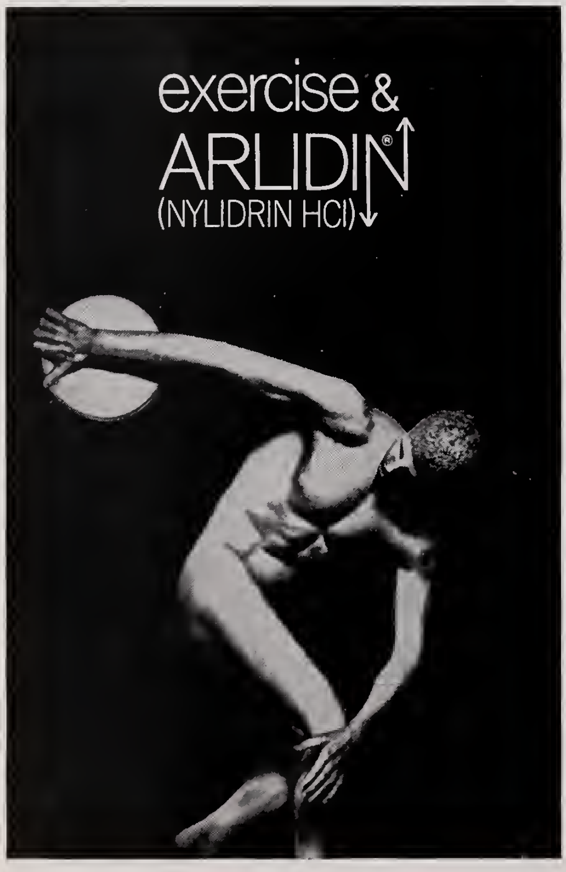
ARTICLES INVITED

A very definite advantage to authors who submit original material to *Michigan Medicine* is the early publication date that is possible in contrast to the time usually required in national or international publications. The Publications Committee welcomes controversial papers as long as they have the merit of being based on well-considered opinion or experience on the part of the authors. Review articles of rapidly developing fields of medicine are also invited.

— George H. Lowrey, M.D.
Scientific Editor

Recommended Reading:

The libraries have available the book by Harriet H. Naylor entitled "Volunteers Today — Finding, Training and Working With Them." The book brings new insights and experience from adult education, social work, sociology and psychology to the problems of getting, developing and holding new kinds of volunteers in the face of keen competition. ☐



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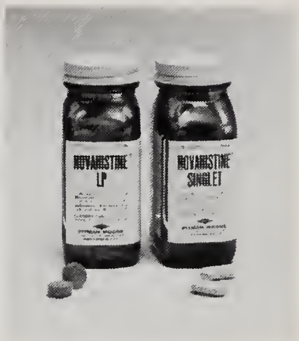

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MAILBAG

Dear Doctor Harris:
I read with interest your "President's Message" in the February issue of *Michigan Medicine*. We are always pleased to learn about people in leadership positions who are giving attention to the importance of health education.

Our staff was particularly interested in your reference to the role of a physician as a consultant to schools and other community groups with respect to health education. As you indicated, physicians do carry on health education every day in the privacy of their consultation rooms, but they also have a responsibility in the community.

We certainly stress the specific points you made with respect to sex education, venereal diseases, general health protection, and drug abuse. We hope, however, that efforts to implement teaching about these significant topics will be part of an overall program of health education in schools and communities.

Sincerely,
Fred V. Hein, Ph.D., Director,
AMA Department of Health Education

I'm extremely pleased with the interest shown by members of the Woman's Auxiliary at the first annual Legislative Day at the MSMS Headquarters in East Lansing.

You are to be commended for having such an excellent staff as everyone at MSMS was most gracious and helpful.

We do appreciate everyone's efforts.

Frances Gamble, President
State Women's Auxiliary

We think the article "A Pediatrician's Cue to Psychiatric Problems of Children" by H. Mark Hildebrandt, M.D., Ann Arbor, in the most recent issue of Michigan State Medical Society AID bulletin, is just what teachers and many other lay people concerned with mental health need to help parents decide when a child needs help.

With your permission, we would like to duplicate the article and also use it in our local newspaper.

Mrs. Lewis M. Birckhead
Mental Health Services Study Group
Grand Haven

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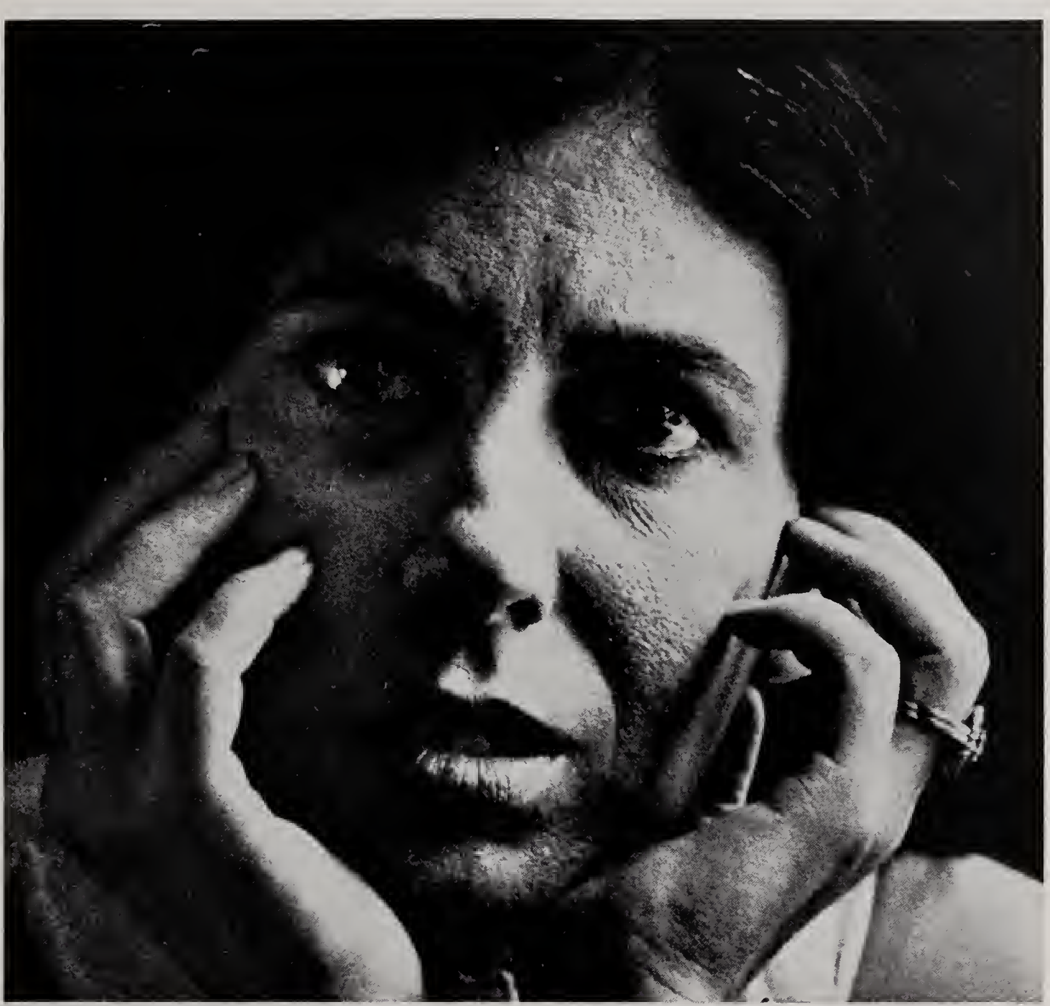

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Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

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Turn page for contraindications, precautions and side effects.

Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy.
10. Because of the occasional occ
rence of thrombophlebitis and
pulmonary embolism in patients
taking oral contraceptives, the
physician should be alert to the
earliest manifestations of the dis
ease. 11. Because of the effects of
estrogens on epiphyseal closure,
NORINYL-1 should be used judi
ciously in young patients in who
bone growth is not complete. 12.
age of the patient constitutes no
absolute limiting factor, althoug
treatment with NORINYL-1 may
mask the onset of the climacteric
13. The pathologist should be ad
vised of NORINYL-1 therapy wh
relevant specimens are submitte

Side effects observed in patients
receiving oral contraceptives: T
following adverse reactions hav
been observed in patients receiv
oral contraceptives: nausea, von
ing, gastrointestinal symptoms (
as abdominal cramps and bloati
breakthrough bleeding, spotting
change in menstrual flow, amen
rhea, edema, chloasma or melas
breast changes (tenderness, enla
ment and secretion), change in
(increase or decrease), changes i
cervical erosion and cervical sec
suppression of lactation when g
immediately postpartum, chole
jaundice, migraine, rash (allerg
rise in blood pressure in suscep
individuals, mental depression.

Although the following side eff
have been reported in users of c
contraceptives, no cause and eff
relationship has been establishe
anovulation post-treatment,
premenstrual-like syndrome, ch
in libido, changes in appetite, cy
like syndrome, headache, nervo
dizziness, fatigue, backache,
hirsutism, loss of scalp hair,
erythema multiforme, erythema
sum, hemorrhagic eruption, it

The following occurrences have
observed in users of oral contra
tives (a cause and effect relatio
has been neither established n
proved): thrombophlebitis, pul
embolism, neuro-ocular lesions

The following laboratory result
may be altered by the use of or
contraceptives: increased sulfo
bromophthalein and other hepa
function tests, coagulation test
(increase in prothrombin, Facto
VII, VIII, IX and X), thyroid fu
tion (increase in PBI and butan
extractable protein-bound iodi
decrease in T^3 values), metyrap
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SYNTEX

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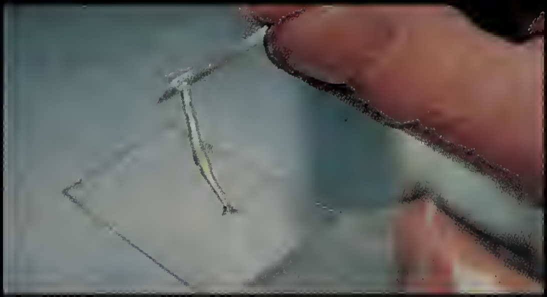
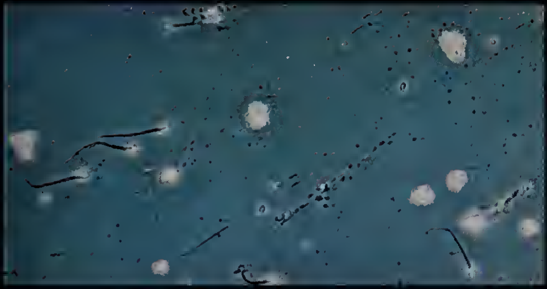
The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

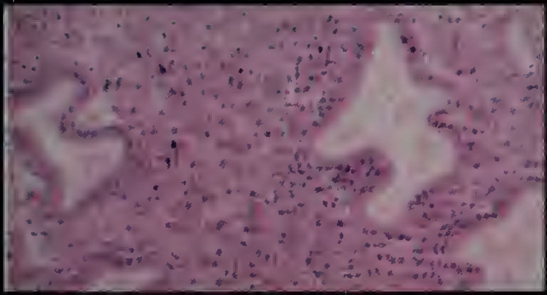
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

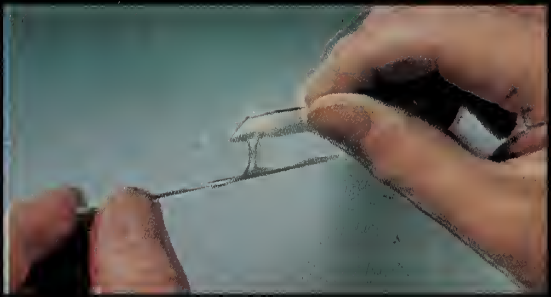


Spermatozoa appear healthy, active, freemoving.

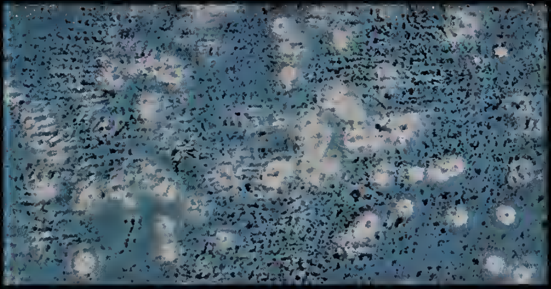


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

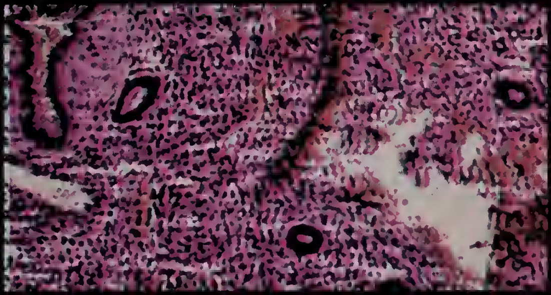
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-l.



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Indications: Hypertension and many types of edema involving retention of salt and water.
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Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol
may potentiate hypotension
cause of the possibility of p
sion of renal damage, perio
determination of the BUN is
cated. Discontinue if the BU
or liver dysfunction is aggr
Hepatic coma may be preci
Electrolyte imbalance, sodi
or potassium depletion may
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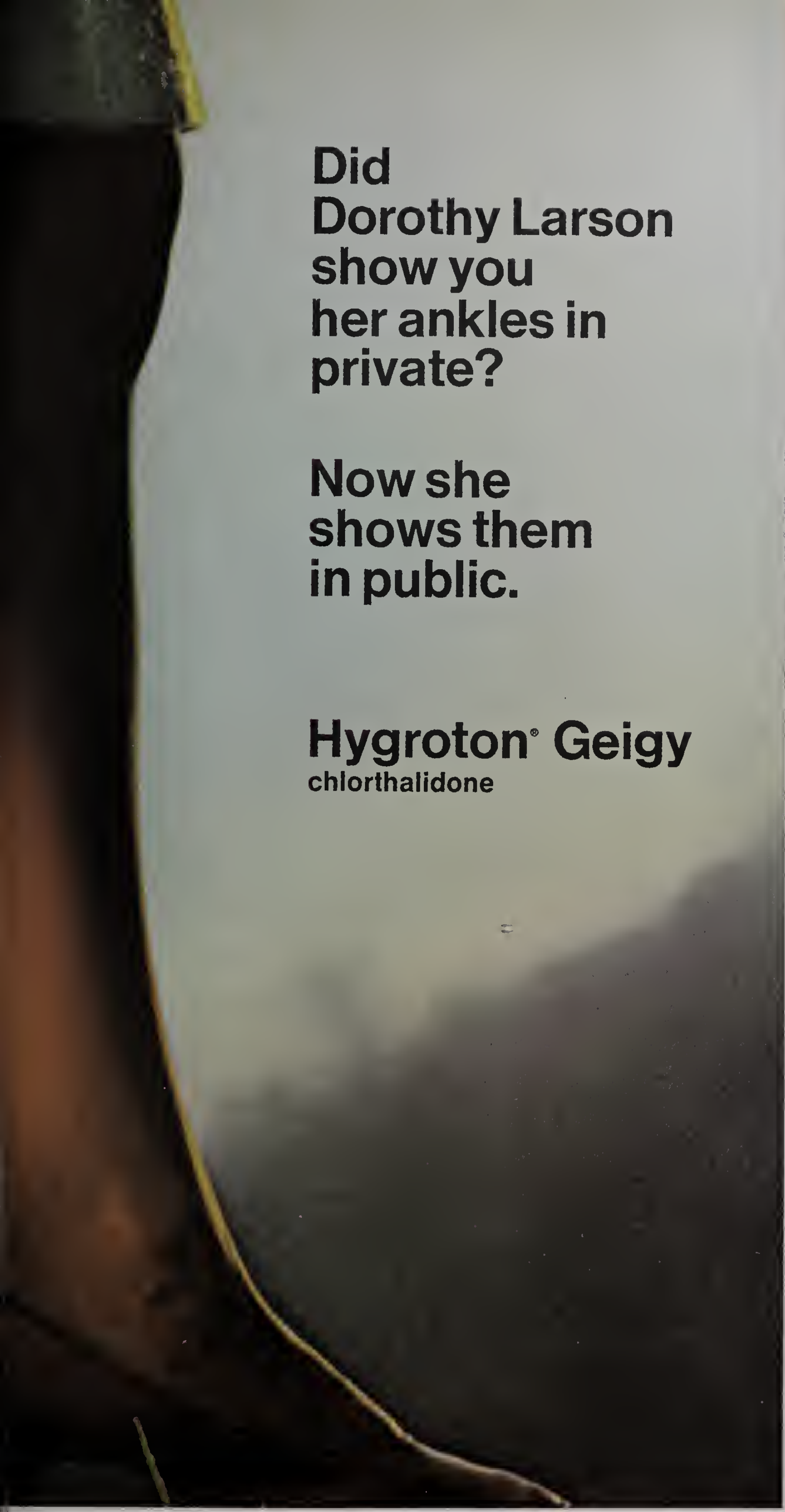

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not recommended.
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vomiting, anorexia, con-
nd cramping, dizziness,
restlessness, hypergly-
peruricemia, headache,
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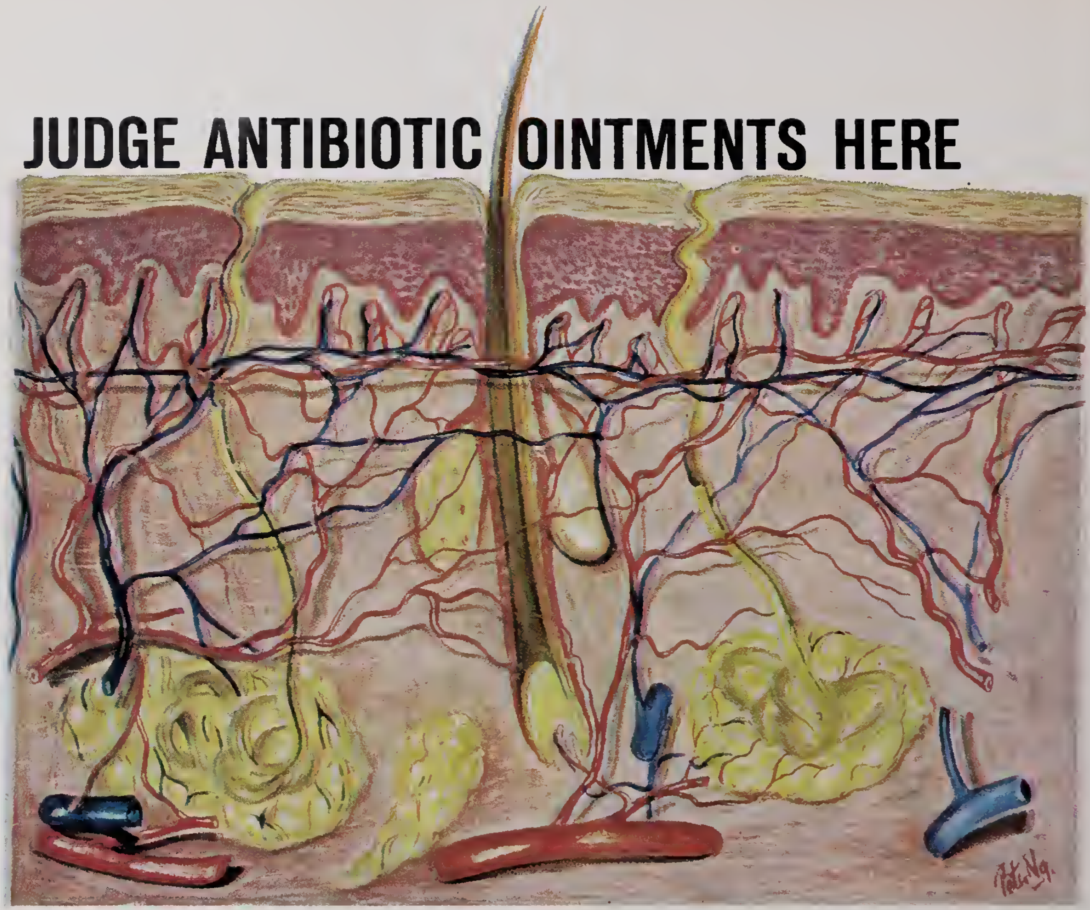

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M.D. Suicides . . . Why?

BY PHILIP M. MARGOLIS, M.D.
ANN ARBOR

At least 25,000 Americans kill themselves each year. I say "at least" because this number reflects only the "recorded" suicides. It is a highly understated statistic, especially when one takes into account automobile accidents, cover-ups, and the complexities of the unconscious. Suicide accounts for the tenth cause of death for all Americans, is in fourth place with teen-agers and is second with college students.

Physicians kill themselves at a rate considerably higher than the rest of the population. Statistics vary but it is clear that physician suicides are four to eight times oftener than the general population.

A SURVEY IN ENGLAND showed that the suicide rate for physicians is 2¼ times that of all males, and the majority of these deaths are of young men (under 45). More than 1 out of 50 male physicians kill themselves per year in England, accounting for 6% of all physicians' deaths (equal to the mortality from lung cancer).

To continue with the deadly statistical game, Freeman and DeSole report that suicide-deaths are highest in the field of psychiatry and ophthalmology, lowest in radiology. From 1895–1965 the physician accident-death/suicide-death ratio was 2 to 1; however, during these seventy years 208 psychiatrists died "accidentally" and 203 suicided (exclusive, of course of "concealed" deaths). And 54 of these 203 have killed themselves during the past five years; 81 did so before age 40. In fact, in the age group 25–39, 26% of physician deaths are suicides, as compared to a general (white) population rate of 9%.

How can these truly alarming statistics be explained?

Theories abound, some more credible than others.

MOST PHYSICIANS WHO commit suicide have been depressed and melancholy. One-half of those who suicide take drugs, which are readily available; with his adequate toxicologic knowledge the doctor is unlikely to misjudge the mortal dose. In fact, many are habitual drug users, even addicts. Some physicians who commit suicide have had "incurable" (medical) illnesses, and undoubtedly have been keenly aware of their incurability.

Why do physicians seem significantly susceptible to a suicidal melancholia?

Freeman suggests that physicians' ideals may be too high, that productivity often falls far short. He feels that many physicians neglect restorative and recreational activities which are intended to balance his intellectual activities underlying his creative drive. He is too task-oriented; he is too intense in his work. In a similar vein, a study at Albany Medical College suggests that the physician is afflicted with psychic tensions due to role strain, i.e., the contention that no roles other than intense and never-ending "doctoring" are available. There is a lack of opportunity for regression, for diversion and sublimation.

FINALLY, THE philosopher asks: Does acquaintance with death free the physician from the popular supernatural dread of it? After all, as Wilde commented in The Ballad of the Reading Gaol (1898), "the Doctor said that Death was but a scientific fact."

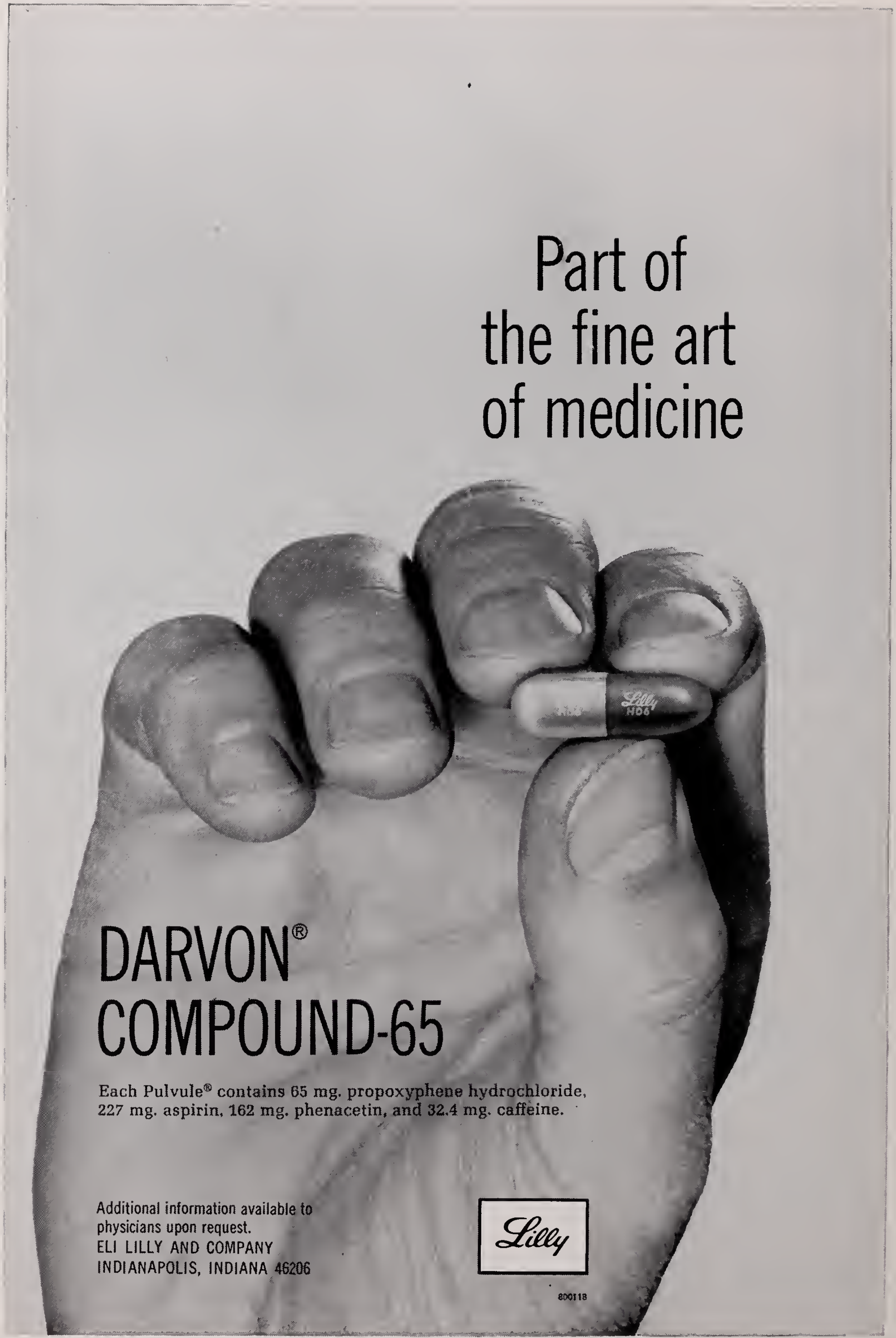
What to do?

Suicidal people usually give clues to their intentions, especially when they are depressed. Physicians are no exception though they may hide their symptoms better than others; the symptoms (at present) are little noticed and scarcely heeded. Physicians should be treated like any other patient, but they never are. Especially when the problems of the M.D. are emotional in nature, the "treater" must seek to understand these problems, at the same time studiously avoiding identification with his patient.

PERHAPS THE ANSWER really lies in prevention. Medical Schools need to pay more attention to the psychic structure of their applicants. For example, Litin suggests that the applicant be able to "shoulder the dependency needs of others." There is also some evidence that a well-rounded academic background (e.g., a solid interest in the humanities) is as or more important than a proficiency restricted to the sciences.

Physician, heal thyself?

Perhaps, but the first step is for him to become a "good" patient, to recognize his need for help and to seek it. If we can know and understand, then we can probably fulfill Maurois' powerful entreaty: to live as if we were eternal.



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Aging, 1968

BY FREDERICK C. SWARTZ, M.D.
LANSING

"Aging" in one concept or another has been a subject of extreme interest to man since the beginning of recorded history. Everyone has talked or written about it. The philosopher, the physician, the priest, the teacher, the poet and musician, the scientist and the researcher have all used the term. The distillate of these writings constitutes a description of the passing scene more than anything else, and, varies appropriately with the climate of the age, or the empire in which the writing occurred. This is true of all the contributions, no matter which discipline is represented. No one, so far as I know, has ever spelled out what they meant by "aging" or the "aging process."

Let me ask: what does "aging" mean to you?

How precise are your concepts of the changes "so-called" wrought by time?

Have you ever stopped to think of the differences that exist between those people whom you called old when you were a youngster, and those whom you call old now?

Has it not occurred to you that the concept of "aging" that existed 100 years ago must have been quite different from the concept of "aging" as it exists today?

WHEN THE GEOLOGIST talks about the aging rock on the hill, he is not referring simply to the passage of time. He uses this term to include those effects wrought by changing temperature, by the wind, by the rain, and by the heat of the sun. This usage, therefore, includes with the effects of the passage of time — if there be any such effects — also those changes wrought by the impact of other environmental forces. This concept of the process of aging admits that many of the results observed are produced by forces other than the passage of time. This is so very important, as we shall emphasize from time to time. It is this concept that gives us hope. It is this concept that gives us an area that we can attack in order to change the so-called process of "aging." All we have to do is modify those environmental factors which have contributed certain effects.

Many people from ancient times to the very present speak about the signs and symptoms, such as the tottering gait, the shaking hand, the white hair, the bald pate, the shrunken shank, the piping voice, the store teeth, the thickening glasses, the forgetful mind, the narrowed mental horizons, and the lack of motivation, the creaking joints, the stiffness and aching, as if these all were a part of a great syndrome which would lead to the diagnosis of the "aging process."

The big question of the moment then is: Are all these characteristics and many others alluded to by various writers the result of the passage of time? If this is true, then at any stated age we should all represent approximately the same proportion of the characteristics listed above and as time goes on we could expect to acquire all the other of the characteristics listed.

IF ALL OF THESE stigmata of "aging" are considered to result because of the passage of time, then there is no possible way for us to modify the final picture of old age. There are some who support this idea, both among the professional and non-professional. I am happy to report, however, that in the past few years more people in the health field are commencing to realize that any and all of the signs and symptoms witnessed among the aging represent some functional derangement related to the presence of a chronic condition or the lack of proper physical and mental exercise and are subject to the correctible methods of modern medicine.

In the more exact sciences we find more exact definitions. Not that we expect to introduce into medical circles this amount of exactness, yet the concept seems to me to be a necessary one. Thus, Boyle's Law says: "With temperature constant the volume of a given sample of gas is inversely proportional to the absolute pressure." And Charles' Law says: "With pressure constant, the volume of a given sample of gas is directly proportionate to the absolute temperature." In these two situations we have regulated those forces which might produce changes which would confuse the results for which we are searching. Therefore, in this concept of "aging," if we could, in essence, block off the effects of environment and cancer cells and bacteria and viruses we ought to witness in an animal or tissue culture those effects which are wrought by time alone. In our search of the literature we have found no such specific example where all possible contributing forces have been eliminated except the passage of time.

Certain disquieting thoughts are disrupting some previous sacred relationship between certain phenomena that were supposed to bear a direct relation to the passage of time.

LET US EXAMINE A few of these for the moment, not really to prove anything very great, but just as an effort to shake the foundations of those who continually talk about "aging" and the "aging process" without coming to grips with a precise concept. We will try, in some of these instances to render unto Caesar what is Caesar's.

The following several paragraphs mention examples of situations where certain phenomena are understood to be related to chronologic age. Closer and more detailed observation of these instances indicates that the phenomena observed are related to other forces and not to the passage of time.

This discussion becomes important because it constitutes the general impression which tends to give weight to the concept in the minds of men that chronologic aging is associated with a certain amount of "degenerative" changes. In order to build more soundly the concepts offered by the Committee on Aging, one has to examine every idea that may offer support to the relationship of degenerative changes and "aging."

It is popularly believed that the study of the rings found in examination of trees indicated their chronologic age. This is essentially true except that the basis for these rings depends on many other factors rather than the passage of time. "Dendrochronology is the study of the chronological sequence of annual rings in trees and aged wood." (According to the *Encyclopedia Britannica*) Tree ring studies are possible because certain species produce growth rings during annual growing seasons. The width of the ring (the amount of growth) for each year is determined by certain internal (genetic, physiologic, and metabolic) and external (edaphic, biotic, and climatic) factors acting on the tree's metabolism. Time is not mentioned. Under normal conditions the internal factors and most of the external ones remain constant year after year. In widespread geographic areas where there is uniform variation in growth activity, resulting in uniform variance in ring widths, the cause of this uniformity is some widespread climatic factor which affects all trees in a similar fashion. In the United States Southwest, for example, tree growth is a reflection of the amount of rainfall. Trees growing in well drained soils rely solely on precipitation for soil moisture and in these locations the quantities of soil moisture is the result of how quickly the rain falls and of the amount of water lost through runoff and evaporation. A soil moisture history can thus be compiled by studying the relative ring width in any given tree growing in such a location. The growth rings in trees whose roots tap a permanent supply of soil moisture are too complacent for such an analysis."

The belief of the deer hunter in the relationship of the antlers to age, has been debunked by scientific studies. Nutrition and not age determines antler size. From this knowledge have come some immediate practical benefits for game management practices. One is the change of state hunting regulations to allow bagging bucks that have only spikes instead of full antlers. Formerly deemed underage, they are now seen as only undernourished. A considerable difference when it comes to evaluating herd densities and population trends.

THE TERM "AGING" and "aging process" gets interchangeably used in many medical articles with the term "degeneration." There is a growing concept that these terms need some definition and some separation. All too frequently the busy scientist when he arrives in the middle or end of his paper and has a few odds and ends that are unexplained, he sweeps them under the rug and says these things are due to the "aging process." More critical minds, however, are commencing to place these changes which are observed at any time in life in the proper category where they belong.

From one of the latest works in medicine dealing with the older patients, a book titled *"Clinical Features of the Older Patient"* by Joseph T. Freeman, we would like to quote several passages that indicate the tendency to recognize changes as being related to the proper etiologic factors and also to indicate that some other changes which are usually associated with the older individual are quite predominantly found in a younger age group.

Dr. Warren Andrew, on page 72 of the above-named textbook, says: "The characteristic of an aging muscular apparatus is the picture of an atrophy of disuse."

On page 91, Dr. Frederick T. Zugibe says: "The failure to date, to define biologic aging adequately resides in the controversey whether ostensible, morphological, bio-chemical or physiological changes are related primarily to senescence or to disease. For many years arteriosclerosis was believed to be a part of old age. More recent investigations have shown the invalidity of the thesis that a man is as old as his arteries. Some septugenarians and octogenarians have been found at autopsy to have coronary arteries relatively free of plaque formations, whereas individuals who die before the age of thirty have shown occlusive atheromatous lesions. Major William Enos, of the United States Army Medical Corps, revealed that about 77 percent of a group of American soldiers in their early twenties, who were killed in Korea, had atheromatous deposits in their coronary arteries. These were heavy in over 40 percent. Such observations are prima facia evidence that atherosclerosis is not an inevitable product of chronologic age alone, but the role of senescence, of course, is not precluded." Dr. Zugibe further states: "The earliest morphological alteration observed in human aortas, coronary arteries and cerebral arteries was a primary deposition of lipids. Lipid was first observed in the aortas of fetuses but was rarely observed in cerebral arteries before fifteen years of age. The lipid was absent in the coronary arteries of fetuses but made its advent the first few weeks after birth.

"IN A STUDY OF ALMOST 6000 cases, a peak in the incidence of arteriosclerosis was found somewhere around the onset of puberty, and appeared to advance more rapidly at this time than at any other time prior to forty years of age. It was noted that 20 percent of the surface areas that contained fatty streaks were converted into fibrous plaques. This occurred before the age of forty, and had taken about 15 years for conversion. The ultimate distribution of the fibrous plaque was in the same anatomical location as the fatty streaks in the younger age group. It was indicated that there are 15 years of life in which these

AUTHOR

Doctor Swartz, author of this article, presented this at an AMA Conference on Aging as chairman of the AMA Committee on Aging of the Council of Medical Service. He recognizes the contributions also of the committee members and the committee consultants.

lesions are of such nature that they can be readily reversed."

Dr. Andrew Fuller says, on page 109 of the same book: "The general management of elderly cardiac patients should differ little from that planned for younger individuals."

And, finally, in this incomplete list of instances where the weight of testimony indicates that age is probably not a factor in the production of any symptomotology or architectural change, we have the quotation from the latest book on emphysema and bronchitis, by Petty and Nette who say, simply: "Age itself does not damage the lungs."

I would like to ask each of you: How old are you? It doesn't matter whether you are 20 or 70. What part of you is 70 years old? You all know that in all living structures the cells are growing and changing and being decimated and destroyed and re-utilized. One doesn't have to take the body part by part, section by section, to discuss the living characteristics of cells, because in essence they are essentially the same. The only one I am not really sure of is the nerve cell. But to make this thing simple, the red cell in the adult human individual is supposed to have a life span of about 120 days. The other cell groups in the body probably vary to shorter or longer periods of time, but certainly none run for 20 years. What then, or what part of you, can thus be said to be as old as your chronologic years?

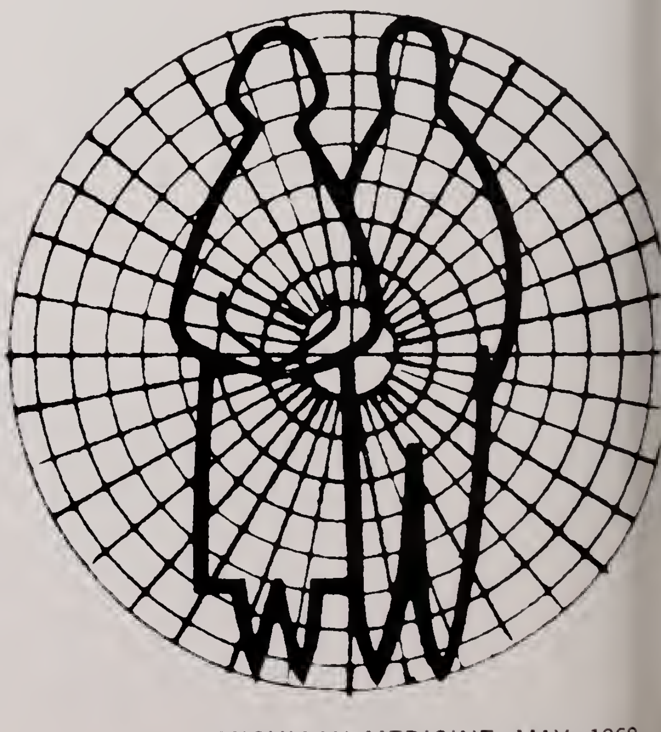
We don't expect, at this time, to have all or a part of the answers. We would merely like to raise in your mind some definite questions about some of the concepts that represent the past and present climates of opinion. We would ask you to be wary of the uncritical acceptance of terms such as degeneration, aging, and the aging process, and we would hope that you could become completely liberated from chronologic snobbery.

THE COMMITTEE ON Aging of the American Medical Association which has studied this whole area for some ten years, has come to the conclusion that they can find no disease entity or physical or mental condition that resulted from the passage of time. Nor was there any prophesied picture or condition that could reasonably be expected to occur in anyone after the passage of so much time.

Although the term geriatrics, which means the study of the diseases of aging, is used quite frequently, the Committee was unable to find any disease entity that was, of necessity, related to the passage of years or time. Arteriosclerotic heart disease, high blood pressure, and arthritis and cancer are found in the youngster; and measles, mumps, chickenpox and poliomyelitis and cancer are found in the oldster. The clinical picture under these circumstances varies only as the seed and the soil vary.

This complete breakdown of past philosophies leads us to pay serious heed to the results coming from recognized research laboratories. More and more it is indicated that the so-called degenerative diseases of man result from the impact of environment on that prefabricated hereditary structure that is man. In the laboratory we see these diseases that occur in animals exposed to hunger, extremes of temperature, lack of oxygen, infections, loss of blood, or fear, with little relationship to the age of the animal. In other laboratories the environment is regulated in the direction of protection for the individual from the effects of environment and we have members living for unbelievably long times.

THE CHRONIC CONDITIONS including the diseases and chronic illness and long-term care cases which constitute the major problems in medicine today, result from the recurring and irritating effects of environment over long periods of



time and are the results of these irritants and not the passage of time.

What must be added to this concept, which does not really come under the heading of recurring and irritating effects of environment, but does come under the less-than-ideal care, that the individual accords the castle in which he lives. The pot belly and flabby muscles that result from the lack of exercise, the loss of habits of study and forgetfulness that comes when the mind is not used, and the painful knees and flat feet that come from long-time pounding by too much weight, present a picture of dilapidation that represents long-time lack of care and is not due to the passage of the hours.

A few years back it was not uncommon to hear the physician say to the patient: "Well, what do you want, a new machine made from all these old parts?" This remark is rarely heard in our present-day medicine.

AGE IS NO BAR to good medical or surgical treatment, including open heart surgery, so long as the patient presents himself as a reasonably, physiologically functioning unit to the physician.

The medical and para-medical services, physician and para-physician personnel must begin to realize that something can be done for the diseases found among the oldsters. The days of condescension medicine to "grandpap" and "grandma" is at an end. The aging are people who are personalities and have names and should be recognized as such. The sense of being recognized and the sense of belonging are considerations that none of us can do without.

May we emphasize again, at this point, that many of the so-called infirmities of age stem directly from lack of conditioning. Great numbers of individuals, after leaving high school or college, settle down to a routine of bread winning which uses only a small portion of their muscular or physical equipment. Under these circumstances it is easy to understand why the physicial horizons become cramped, why the hand shakes, and why the gait becomes uncertain and tottery. This being true, it behooves the young and old to continue some type of physicial development and exercise throughout life instead of neglecting these important duties after leaving school.

Forgetfulness and mental retardation result largely from lack of attention and failure to concentrate, and loss of motivation. This can largely be prevented if we will all continue to encourage some habits of study learned in school. Some serious reading and thinking should be a part of each man's daily life. The muscles are strengthened and the wits are sharpened only by proper physical exercise and mental activity.

OUR WHOLE PROGRAM, aimed at retarding the aging process, so-called, by improvement of physical and mental activity, would fall short of accomplishment if we did not at the same time strike a blow for moderation in the use of alcohol, tobacco and food.

Much propaganda must be directed to the already brainwashed oldster, and increasing efforts must be made to prevent the brainwashing of those coming behind him. The fatal concept that debilities come with age and at sixty-five one is over the hill, condemns the oldster to a period of ever narrowing horizons until the final sparks of living are the psychoneurotic concerns with the workings of his own body.

Aging is really living, growing and developing, so that the final days and contributions should be far different in the future than they seem to be today.

Further retarding of the "aging process" can be accomplished through other professions, through parents and teachers, all by selling some degree of self-discipline to the coming generations. This to such an extent that a program of physical exercise and good posture, daily mental exercise, not of the bread-and-butter kind, and careful regulation of body weight, become the principal rules of living. Add to this the protection of our present immunization program and cap this off with periodic health appraisal programs and the life expectancy figures should increase ten years in one generation.

IN CONCLUSION, we hope that we have shattered the present concept of an aging process. What we see instead is a hereditary package, buffeted by the wind and wave and weather of environment. This package is not like a sailless, rudderless ship. It is the most magnificent creation in the universe. Overlay this with emotional veneer which does not seem to be based on chemistry or physiology, but is equally capable of influencing the destiny, and you get some idea of a composite picture of Man, none of which is dependent on the "aging process," so-called.

The oldster, with his problems of health and disease, can look to the future with hope. The generally considered unchangeable, incurable, etiologic factor "aging process" has been eliminated. The oldster has become as treatable as any other age group and often responds as well.

Morituri Salutamus

But why, you ask me, should this tale be told
To men grown old, or who are growing old?
It is too late! Ah, nothing is too late
Till the tired heart shall cease to palpitate.
Cato learned Greek at 80; Sophocles
Wrote his grand *Oedipus,* and Simonides
Bore off the prize of verse of his compeers
When each had numbered more than fourscore years.
And Theoprastus, at fourscore and ten
Had but begun his *Characters of Men.*
Chaucer, at Woodstock, with the nightingales
At sixty wrote *The Canterbury Tales.*
Goethe, at Weimar, toiling to the last
Completed *Faust* when eighty years were past
For age is opportunity not less
Than youth itself, though in another dress
And as the evening twilight fades away
The sky is filled with stars — invisible by day.

MEDICAL MEMO

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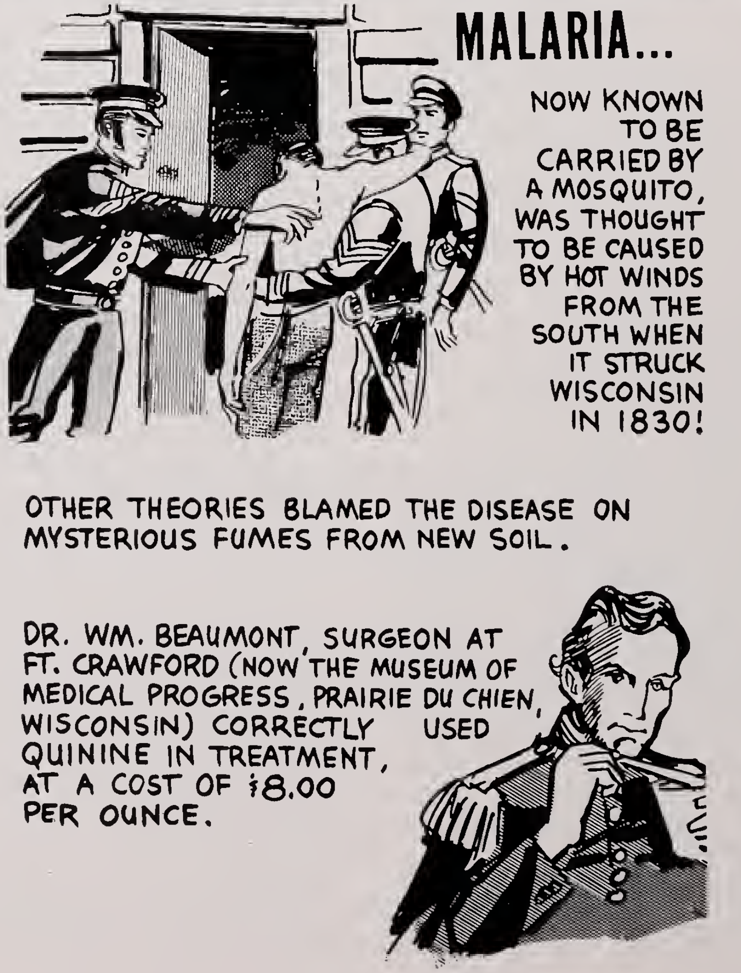
MALARIA...
NOW KNOWN TO BE CARRIED BY A MOSQUITO, WAS THOUGHT TO BE CAUSED BY HOT WINDS FROM THE SOUTH WHEN IT STRUCK WISCONSIN IN 1830!
OTHER THEORIES BLAMED THE DISEASE ON MYSTERIOUS FUMES FROM NEW SOIL.
DR. WM. BEAUMONT, SURGEON AT FT. CRAWFORD (NOW THE MUSEUM OF MEDICAL PROGRESS, PRAIRIE DU CHIEN, WISCONSIN) CORRECTLY USED QUININE IN TREATMENT, AT A COST OF $8.00 PER OUNCE.

The Bulging Fontanelle Syndrome Following Tetracycline Administration

ABSTRACT: The administration of a tetracycline preparation in a five-month-old infant resulted in the development of a bulging fontanelle within the first twenty hours after the first dose. Although the mechanism for the increased intracranial pressure is not clear, there were no signs of serious central nervous system involvement. Withdrawal of the antibiotic resulted in rapid return of the fontanelle to normal.

BY SEYMOUR KREVSKY, M.D.
DETROIT

The clinical use of tetracyclines has become associated with a number of new entities, not the least of which is the "bulging fontanelle syndrome." Since its first description a decade ago, the relationship of the bulging fontanelle to the use of the drug has been more frequently reported. To emphasize the brief period of administration prior to onset and the rapidity of development, as well as the lack of any associated untoward reactions, this case is presented.

Report of Case

A five-month-old male infant was first observed by a physician because he had run a fever and been irritable for 36 hours.

The past history of the infant was well known, the child having been born in the hospital nursery. He was a slightly premature baby, weighing four pounds, ten ounces at birth.

At five weeks of age he was put on iron medication. Treatment was continued until he was 12 weeks old. Immunization with triple antigen (DPT) was begun, with a repeat dose 10 days before the onset of his present illness.

On initial examination the infant had a fever of 101.5 degrees and showed signs of a severe upper respiratory infection, although alertness was not impaired and suppleness of neck and back was not impaired. A throat culture and blood count were taken, and the child was put on an antibiotic preparation because of the severity of the reaction.

The antibiotic was a liquid preparation containing 125 mgms. tetracycline hydrochloride per 5 cc dose. The first dose was at one p.m. with repeat in six and twelve hours. Early the next morning he was again seen in consultation for reevaluation. The picture had now changed. Although fever was still present, as high as 101.4 degrees F., no resistance to neck or back suppleness was observed. Some irritability was present. The pharynx was slightly inflamed and ear drums showed no inflammatory changes. There were no rales, wheezes or rhonci present in lung fields. A soft systolic murmur was heard, without any arrhythmia. The most prominent finding, however, was a marked bulging of the anterior fontanelle. No prominence of the fontanelle had been present the day before, nor on any previous examination. The head circumference measurements were within the standard range for age.

Although an anemia of considerable severity was present, with a hemoglobin of 6.8 gms., the white blood cell count was not elevated, and there were on increases in the number of polymorphonuclears of lymphocytes. Skull x-rays were normal, as was a chest x-ray. Electroencephalogram was not abnormal. Spinal fluid examination was performed the following morning, at which time the bulging of the fontanelle had diminished to some degree. The spinal fluid showed a slight to moderate increase in pressure; but no cells. Culture after 48 hours was negative.

The child was taken off of the antibiotic immediately on admission to hospital. Improvement of

AUTHOR

Doctor Krevsky is associated with the Pediatrics Department of the Detroit Memorial Hospital and South Macomb Hospital.

his general condition progressed very readily. Fever subsided after 48 hours. Cheerfulness returned in 24 hours. The bulging of the fontanelle gradually subsided so that on the third day of hospitalization it was considered flat, and no increase in pressure has subsequently been reported. There has been no abnormal increase in head circumference size. The anemia was treated with parenteral iron and responded very rapidly. Physical and mental development have proceeded satisfactorily.

Comment

The development of intracranial hypertension in an infant manifested by a bulging fontanelle following the administration of a tetracycline compound has become fairly well known over the past decade as the use of these compounds has increased in the pediatric age group. In the effort to understand the basic pathogenic process involved a careful review of all reported cases is essential. Although there have been several comprehensive studies of the untoward reactions of the tetracyclines, the mechanism whereby intercranial hypertension is produced remains obscure. In this particular instance, as in previously reported cases, the dosage administered was low, well within the recommended safety margin; and the small number of doses, three, was sufficient unto itself to cause prompt return of the fontanelle to normal.

The question of whether to perform an immediate lumbar puncture in the presence of markedly increased intracranial pressure has been raised by several investigators. In our case it was decided to wait until the bulging showed signs of decreasing. Since the infant was crying the actual pressure was not measured.

Although a moderately severe anemia was present, which may have contributed to the development of the original infection, it did not contribute to the development of the cerebral hypertension. This could require further evaluation if similar cases showed a reciprocal relationship.

Summary

A five-month-old male infant with a severe upper respiratory infection and a very strong febrile response was treated with a tetracycline preparation. After three doses he developed a marked bulging of the fontanelle which could not be associated with the disease process. The withdrawal of the medication was followed by rapid return of the fontanelle to normal state. There has been no recurrence of similar difficulties with the infant. ☐

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Explains further Efforts to Improve State Mental Health Department

(Editor's Note: In this article, the Director of the Michigan Department of Mental Health reports on the downward trend in resident patient care. He also reviews the reasons for deficiencies in capacity to operate the state institutions. Doctor Anderson expresses hope for further significant program improvements and discusses in some detail five internal improvement objectives.—George W. Lowrey, M.D., Scientific Editor.)

BY WM. H. ANDERSON, M.D., DIRECTOR
MICHIGAN DEPARTMENT OF MENTAL HEALTH

As a result of the introduction of modern psychotropic drugs, the extended use of family and nursing home care, and the increasing emphasis on early treatment at the community level, there has been a downward trend in the resident patient census in Michigan's state hospitals since 1957, matching a national trend.

Continued prosperity, higher mental health appropriations, and new ideas for delivering services have given rise to the hopeful anticipation of significant program improvements. Some have indeed occurred.

It is also true that Michigan is a progressive state that has always maintained better than average services for its citizens. Despite all of this, there are persistent and sometimes serious deficiencies in our capacity to operate the institutions of the Department of Mental Health—the eight state hospitals, seven state home and training schools, and other specialized facilities.

The reasons are not hard to find.

ALTHOUGH THE RESOURCES available to the Department are much greater than in 1957, the distribution has been uneven. In general, community mental health services and home and training schools for the retarded have received larger shares of the new money than other elements. At the same time, demand has risen in almost every category of service supplied by the state hospitals, except day-to-day care of the resident population.

Admissions, intensive treatment services, placement, after-care, and out patient treatment all reflect a greater workload, notwithstanding the

availability of new and expanded community services. Furthermore, the increased expenditures to combat mental retardation went largely for expansion of the home and training schools rather than for improvements, except as they were incidental to the expansion.

THE STATE HOME and training schools and the state hospitals currently have equal difficulties in their efforts to maintain program quality. In fiscal 1967-68, neither group of institutions received a sufficient increase in appropriations to cover Civil Service pay increases, and both groups had to reduce employment levels. In addition, effective work by patients, which has always been an important factor in institutional economies, has been declining as a consequence of more effective treatment and discharge policies, leading either to loss of service or need for replacement by paid personnel.

Superimposed upon these considerations is an accumulation of miscellaneous problems resulting from chronic underfunding, coupled with residuals of outmoded systems of service delivery.

Much hope has been placed upon the ability of community mental health programs to assume a substantial share of the treatment responsibilities now carried by state facilities, thereby reinforcing the trends toward reduction in size and increase in efficiency of our institutions. Communities do not find it easy, however, to provide all the services necessary for the complete management of their mentally ill or retarded populations. In fact, it is not even possible in any organization model which does not provide for extended inpatient service.

When general hospitals furnish the inpatient element of community services, as they usually do, extended care is not economically feasible in most cases. The state will undoubtedly be required to continue to fulfill this need for the foreseeable future, but the number of beds that will be required has not been determined.

DESPITE THE FACT that state hospitals operate at a fraction of the cost of community hospitals, bed for bed, it is unlikely that significantly expanded budgets will ever be available to the state institutions. Not only is the magnitude of the requirement formidable, but there is no historical precedent or national example for adequate funding of public mental institutions.

There are also new factors in the health and welfare economy working against mental hospitals at both state and national levels. One of these, of course, is the diversion of mental health dollars to community services. This will prove to be a liability only if these services fail to fulfill their promise. Even larger sums are being drawn into non-psychiatric health, welfare and rehabilitation programs, some of which have federal matching provisions which discriminate against the state institutions. Their future, therefore, cannot safely be allowed to depend solely upon increased support.

Reductions in caseload combined with internal operating improvements seem to offer greater promise for upgrading the treatment programs. The correlative assumption is that no reduction in support will accompany the lessening of caseload.

SOME OF THE State Department's specific improvement objectives, oriented to the considerations outlined above, are the following:

I. Management improvements.
II. Data system improvements.
III. Clearer statements of objectives and standards, and refinement of program budgeting techniques.
IV. Continued acceleration of patient movement.
V. Further development of alternative methods of delivering psychiatric services.

Each of these is discussed briefly:

I. Management Improvements

Keeping up with technological advancements and finding better ways of doing things is a constant challenge in a large hospital system. The systems approach, which should be highly applicable, has characteristically encountered difficulty when applied to public service departments, particularly at the point of implementing recommendations. This, at least, has been the experience of the Department of Mental Health and it tends to be confirmed by others.

The apparent inability of public service departments to conduct and implement routine, systematic cost-effectiveness studies has been ascribed most frequently to the rigidities and resistances which characterize such departments, and to lack of top level support. This is tantamount to displacing the failure from the analyst to the system. In fact it may be viewed with equal logic as a deficiency in external design (i.e., the analyst's lack of appreciation in depth of the complexities and constraints of the organization.)

The Department of Mental Health hopes to overcome some of the difficulty by combining existing problem-solving resources in a single division independent of the operating divisions, and by giving approved projects top staff support. It is assumed that any recommendation for management improvement which does not have visible value to professional staff will encounter difficulties at the point of implementation in a hospital or home and training school. There must be close professional collaboration in all projects. Insistence on this should improve the design of our projects on one hand, and acceptability of results to operating staff on the other.

II. Data System Improvements

Modernization of the data system of the Department of Mental Health is needed for better clinical programming, as well as for management improvements. Current information inputs, although inadequate, exceed current processing capacity. The Legislature has previously appropriated money to study this problem. In 1968 the Department is requesting money for first stage implementation of its modernization plan.

III. Program Objectives, Standards, and Budgeting

Under the present state administration there has been a transition to a planning-programming-budgeting (PPB) system in which requests for money are based on plans to achieve specific functional objectives, rather than to support structural entities which tend to carry out loosely stated functions. Under a PPB system it is necessary to identify goals and provide descriptions of individual programs and to relate these to institutional and departmental goals.

An example of an individual program would be "growth and development" in which mentally retarded children with certain characteristics and potentials are carried through a sequence of very basic training activities leading to eligibility for more advanced programs. Although it may not be well known around the state, this system has contributed to some remarkable improvement in the institutions for the mentally retarded, and the same principles are being extended to the hospitals for the mentally ill. Unfortunately, money has not been obtained for all programs which are possible, so there are contrasts between institutions and between parts of institutions, but the method and the programs are available, subject to the availability of money.

In traditional medical programming, the tendency has been to group patients by diagnosis, age, place of origin, convenience of the responsible physician, or some other concept or combination which was unrelated or, at best, secondarily related to individual needs for treatment or training. Grouping by functional needs (as in intensive nursing or self-care units in general hospitals) is more compatible with good budgeting practice in addition to being a recognized means of achieving personnel economies and optimum utilization of skills. It is sometimes necessary to modify the degree of task specialization inherent in this concept in order to achieve some other desirable feature, such as continuity of care by a single treatment team.

The qualitative, and indirectly the quantitative, aspects of programs are controlled through the adoption of standards. This has been an apparent weakness of the Department of Mental Health. Its standards have tended to suffer erosion under the stress of inadequate financing and the demand for increased volume of services — conditions which usually exist. The restatement and enforcement of standards are certain to produce conflict at times, but are necessary to effect program improvements. These, combined with refinement of program statements for budget purposes and efforts to obtain more complete funding of existing programs, will hopefully be recognizable features of departmental activity in the immediate future.

IV. Acceleration of Patient Movement

Policies designed to prevent stagnation, institutionalization, and ineffective living are not new and they have not been unsuccessful. However, the massiveness of the problem is illustrated by the fact that there are still about 27,000 patients in Michigan state mental hospitals and home and training schools for the mentally retarded.

It is necessary to maintain an adequate level of domiciliary care for large numbers of chronic patients in addition to coping with a steadily increasing demand for intensive treatment services. To do this, programs must be broadly based to meet a variety of needs. It is intended to give priority to those elements which are highly restitutive or rehabilitative in nature as contrasted with those designed mainly to improve comfort or adjustment of patients within the institution. Building programs will emphasize maintenance and remodeling for alternative uses rather than expansion. There will be continuous, vigorous efforts to find other suitable homes for patients who do not need further hospitalization. Efforts will be made to recruit and reward staff on the basis of ability to produce dynamic programs.

V. Further Development of Alternatives

Assigning to state institutions those mental health responsibilities no one else wants is a weak approach to statewide programming. Not only does it fail to coordinate positively the efforts of state, community, and private sectors, but it also tends to retard desirable developments in community programs by seeming to render them unnecessary.

The role of state institutions must be actively delineated, just as are community and private roles. No one can say at this time exactly what the state role will ultimately be, but the responsibilities of the state would appear to be mainly for intermediate range treatment, long-term hospitalization of refractory cases, and participation in community plans where appropriate.

The principal existing alternative to care in state institutions is, of course, care in community facilities. Community programs must be strengthened. At the present time many of them have not made adequate provision for the care of very ill persons, nor are they working closely enough with state facilities to provide selected elements of care in a span of illness, for example, after-care following a period of treatment in a state hospital.

In some instances, Department Consultation Centers (out patient clinics for aftercare of patients discharged from state hospitals) are functioning in the same cities, in one instance in the same building, as state supported community clinics. It certainly will be a high priority objective of the Department of Mental Health to obtain a better delineation of roles than this implies and, within the framework of autonomy desired and needed by community boards, to achieve state-community coordination in the development of a unified mental health program for the state.

The Department is also working with several mental health related agencies to develop additional alternatives to institutional care, especially with the Department of Social Services and with the vocational rehabilitation and special education divisions in the Department of Education.

Summary

THESE ARE RATHER broad objectives, of course, and none of them will produce immediate or startling results.

An interesting feature of public mental hospitals is their tendency to look the same from one century to another. A number of writers have made a game of showing that we are still solving the same problems that people one hundred years ago thought were being successfully solved. Although psychiatry is far from a perfect science, and although important new discoveries may come at any time, the means are already at hand to do

AUTHOR

Doctor Anderson is the Director of the Michigan Department of Mental Health.

a far better job than we do. This suggests that the issues are at least as much political, economic, and social as they are medical.

Our immediate improvement objectives tend to emphasize techniques designed to cope with these non-medical limitations by maximizing efficiency and redistributing the workload in ways that should make it easier subsequently to follow-up with specific advancements in treatment, research, and training. Better care consistent with economic principles, but not economy per se, is, after all, our ultimate goal. □

Practical Management Of The Anovulatory Patient

ABSTRACT — Success is now anticipated in the treatment of the anovulatory patient whereas failure was the most likely prognosis in the past. This is primarily due to the availability of clomiphene citrate, an ovulatory stimulating drug. The release of clomiphene has made the accurate diagnosis of the cause of anovulation to be more pertinent; however, the close observation of the patient during treatment is mandatory.*

BY HARRISON C. VISSCHER, M.D.
ROBERT D. VISSCHER, M.D.
GRAND RAPIDS

The recent release of clomiphene citrate*, a drug to stimulate ovulation, is a real milestone in the successful therapy of the anovulatory patient.

Because of this success, there has been a renewed interest in the medical management of these patients. The purpose of this article is to present a practical approach in evaluating and managing anovulatory patients, using the diagnostic procedures that are economically feasible and are generally available throughout the state. With respect to clomiphene itself, our comments are based on reports already in the literature[1-7] and on our own experience in dealing with clomiphene as an investigational type drug from September 1965 through June 1967. During this time 26 patients were treated with clomiphene.

Results

The diagnosis pertaining to the cause of anovulation in these 26 patients are listed in **Table I.** Results of therapy in each diagnostic category are listed in **Table II.** There were four patients who were not married. One patient had had a previous tubal ligation but desired a diagnosis for amenorrhea and wanted to menstruate. One patient changed her mind during her diagnostic studies and desired to put off attempts at pregnancy. She was given clomiphene to confirm the diagnosis and prove the ability to be able to induce ovulation. Therefore, in this study we considered 20 patients eligible for pregnancy. Thirteen of these 20 patients became pregnant.

Complications occurred in two patients, one with ovarian dysfunction and one with androgenic adrenal hyperplasia. They both developed ovarian cysts larger than 10 cm. with moderately severe pain. The cyst and symptoms subsided spontaneously. Of interest is the fact that both had residues of previous salpino-oophoritis at the time of prior culdoscopy.

Discussion

Clomiphene is a synthetic drug taken orally which has the ability to stimulate ovulation in selected patients. The exact mechanism of action of this drug is not known in detail, but the most popular concept at this time is that clomiphene has an anti-estrogen effect. It seems that this anti-estrogen effect mediates itself through the hypothalmus and pituitary, causing a subsequent increase in pituitary gonadotropins which stimulate the ovary to produce hormones and ovulate. There is also some question as to whether or not clomiphene has a direct action upon the ovary itself.

Because clomiphene is related to other compounds that have significant adverse side effects, and because there are several important unan-

Table I. Results in 26 Patients Treated with Clomiphene

A. TOTAL PATIENTS	26
B. DIAGNOSIS	
1. Hypothalamic disease	3
2. Pituitary disease	1
3. Adrenal androgenic hyperplasia	4
4. Ovarian failure	1
5. Ovarian dysfunction including polycystic sclerotic ovaries	17
C. RESULTS	
1. Ovulation	
a. yes	20
b. no	4
c. uncertain	2
2. Patients eligible for pregnancy	20
3. Pregnancy	13
a. abortions	4
b. fetal death	0
c. liveborn	7
premature	0
mature	7
d. neonatal death	0
e. still pregnant	2
4. Complications	
a. ovarian cyst with pain	2
b. multiple pregnancy	0

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* Clomiphene citrate used in this study was obtained as Clomid from the Wm. S. Merrell Company, Cincinnati, Ohio.

Table II. Results in Treatment of 26 Patients with Anovulation

DIAGNOSIS	NO. OF PATIENTS	OVULATED	PATIENTS ELIGIBLE FOR PREGNANCY	PREGNANCY
Hypothalamic	3	0	1	0
Pituitary	1	0	1	0
Adrenal	4	4	3	3
Ovarian Failure	1	0	1	0
Ovarian Dysfunction	17	16	14	10

swered questions regarding the use of clomiphene, it is generally agreed that this drug has to be used with caution. Judicious selection of patients with close follow-up is mandatory. The William S. Merrell Company which synthesizes the drug, lists only one approved indication for use at this time. They state that clomiphene is indicated for the treatment of ovulatory failure in patients desiring pregnancy under certain circumstances.

Anovulation is not a specific disease entity; it has many causes, some of which are significant, and should be diagnosed and treated specifically.

THEREFORE, HOW DOES one astutely pick out the patients who will most likely respond successfully to clomiphene, and still not miss other significant diseases that should be handled in a different way? Our purpose, then, is to present a practical approach to the proper selection of such patients for clomiphene therapy.

These patients usually present themselves to the physician because of infertility or secondary amenorrhea. **Figure I.** gives an outline of our approach to these patients. In order to prove anovulation, consider its etiology, and select those patients best suited for therapy, we feel that the physician should obviously take a good history and do a complete physical examination. This history and physical should be endocrine oriented, and attempts should be made to rule out constitutional and systemic diseases. Pregnancy must be ruled out in any patient with amenorrhea in the child bearing age.

The patient should keep a basal body temperature chart for at least two or three months, with an endometrial biopsy done on the appropriate day. If the patient is menstruating, we prefer that the biopsy be done on the 24th day of her cycle. A vaginal smear in the absence of vaginitis is helpful for hormonal evaluation and can also be useful in determining the presence of Barr bodies or chromatin bodies. A routine cervical and endocervical cancer detection smear is also important, especially if abnormal bleeding is present. Examination of the cervical mucous for amount, viscosity, clearness, and ferning is useful in evaluating ovarian function. Serial evaluation of vaginal smears and cervical mucous could be even more meaningful.

Clomiphene is primarily useful in patients with adequate endogeneous estrogen. In this regard, the most useful clinical test for us has been the progesterone withdrawal test. A pure type of proges-

HARRISON C. VISSCHER **ROBERT D. VISSCHER**

CO-AUTHORS

Doctors Harrison and Robert Visscher are co-directors of Education and Research in the department of OB-GYN at St. Mary's Hospital and on the attending staff at Blodgett Memorial Hospital.

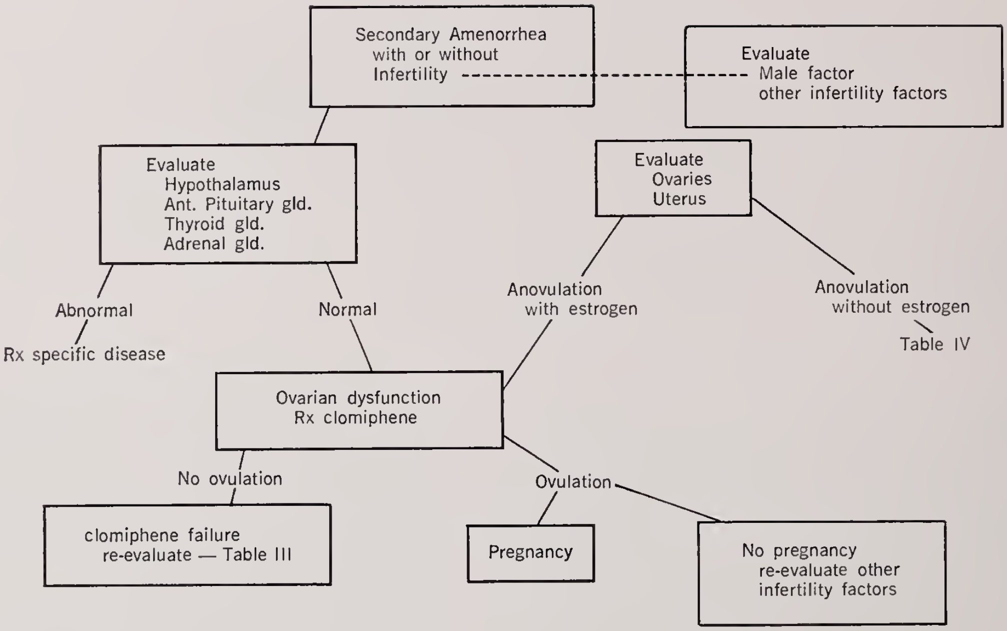
Secondary Amenorrhea with or without Infertility
Evaluate Male factor other infertility factors
Evaluate Hypothalamus Ant. Pituitary gld. Thyroid gld. Adrenal gld.
Evaluate Ovaries Uterus
Abnormal
Rx specific disease
Normal
Anovulation with estrogen
Anovulation without estrogen
Table IV
Ovarian dysfunction Rx clomiphene
No ovulation
Ovulation
clomiphene failure re-evaluate — Table III
Pregnancy
No pregnancy re-evaluate other infertility factors

Fig. 1 — Outline for diagnosing anovulation and its causes

terone must be used. We use oral medroxy progesterone acetate 10 mgm.* per day for five days, and expect withdrawal bleeding two to four days after stopping the progesterone. As previously mentioned, the vaginal smear and endometrial biopsy also help in evaluating the endogeneous estrogen level. Other basic tests that we use are: an examination of the visual fields, PBI, and a 24 hour urine for 17 ketosteroids and pituitary gonadotropins.

In addition to the history and physical examination, these tests serve as screening procedures to rule out gross abnormalities of the hypothalamus, anterior pituitary, thyroid, and adrenal gland as possible sources of anovulation.

IF INFERTILITY IS part of the problem, it is important that the male partner be judged fertile by doing a urologic examination and semen analysis. A Huhner (post coital cervical mucous evaluation) test and tubal patency test should also be performed in the infertile female.

If all the above tests are normal, except those indicating anovulation, i.e., basal body temperature chart, endometrial biopsy, vaginal smear and cervical mucous, then the patient is an excellent candidate for clomiphene therapy. There is some rational for inducing uterine bleeding before starting clomiphene or not attempting pregnancy until the second induced ovulation. The starting dose is 50 mgm. per day for five days starting on the fifth day of the cycle. If after the first month, the patient does not respond, then the dose is increased to 100 mgm. per day for five days. The patient must be followed closely, using the basal body temperature chart and a monthly pelvic examination immediately before the next dose of clomiphene is started. The minimum time between doses should be 30 days. If the basal body temperature chart shows a temperature elevation, the next dose should not be given until it drops, the woman menstruates, or pregnancy is ruled out. If clomiphene is going to work, it usually does so within three cycles of therapy, frequently working the first treatment cycle.

Of course, pregnancy is the ultimate in proving an ovulatory response. But short of this, the use of the basal body temperature chart and the endometrial biopsy is the most practical means of evaluating success in inducing ovulation. If clomiphene does not stimulate ovulation, then the patient is classified as a clomiphene failure, and another course of action must be instituted.

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* Provera — Upjohn

THE MOST COMMON side effects with clomiphene therapy are ovarian cysts, lower abdominal discomfort with bloating secondary to ovulation, hot flashes, blurring of vision, and nausea. The higher the dose used and the larger the ovary to start with, the more likely one is to get overstimulation and ovarian cyst formation. This is one of the reasons that a pelvic examination must precede any repeated course of therapy. If the ovaries are enlarged, no further clomiphene should be given until they recede in size, and then the dose should be reduced. One should be careful not to overtreat these patients with enlarged ovaries. Surgery should only be performed if the patient develops an acute surgical abdomen along with an ovarian tumor.

As with other ovulatory drugs, the incidence of multiple pregnancy increases with clomiphene therapy. Approximately 10 to 12% of the patients who become pregnant will have a multiple pregnancy. Pregnancy itself is actually a contraindication to the use of clomiphene. Although no adverse effects have been demonstrated on the human fetus, there has been some animal evidence to suggest such, and therefore this potential problem has to be further evaluated.

With those patients who do not respond to clomiphene, further investigation should be carried on. The first step with clomiphene failures is to thoroughly re-evaluate the patient.[7] **Table III** lists items to be emphasized when re-evaluating these patients. The physician must consider the possibility that he may have the wrong diagnosis. Rather than ovarian dysfunction, he might have a hypothalamic, pituitary, thyroid, or adrenal problem. Ovarian failure or dysgenesis are other possible diagnoses. In order to further evaluate the patient, other tests are in order, some of which are not always readily available. If the indicated tests are not available to the physician, he should consider referring the patient.

Table III. Evaluating Clomiphene Failures

A. Re-evaluate history and physical
B. Pituitary gonadotropins
C. Skull X-ray
D. Visual fields
E. Culdoscopy
F. Adrenal gland evaluation
    1. Dexamethasone suppression test
    2. ACTH stimulation test
    3. Metopirone test
    4. Plasma cortisol
    5. Electrolytes, GTT, etc.
G. Consider neurological consultation
    1. Pneumoencephalogram
    2. Arteriogram
    3. EEG
H. Chromatin
I. Chromosomes (karyo-typing)

One of the tests indicated would be an evaluation of the pituitary gonadotropins, FSH and LH. The newer immunologic methods of evaluating LH are becoming more reliable and available. These can be helpful in differentiating between a pituitary abnormality and ovarian failure. Skull X-rays and pneumoencephalograms may be needed to rule out central nervous system disease.

CULDOSCOPY IS ALSO very helpful in these patients if it has not been done previously. It is a good means of visually evaluating the ovaries and checking for pelvic adhesions and other diseases of the uterus, tubes, and ovaries which may interfere with reproduction. If the patient has primary amenorrhea, or a possibility of ovarian dysgenesis, chromatin and chromosome studies should be instituted. Recently, it has been shown that some patients with secondary amenorrhea can also have chromosome abnormalities of a mosaic type.[8] The above studies should more clearly

Table IV. Evaluating Higher Areas Affecting Ovulation

A. INDICATIONS
    1. Anovulation without endogenous estrogen
    2. Atrophic vaginal smear
    3. Atrophic endometrium
    4. No progesterone withdrawal bleeding
    5. Clomiphene failures
B. PROCEDURE
    1. Pituitary gonadotropins
        a. Method
            1) Bio assay
                24 hour urine
            2) Immuno assay
                24 hour urine
                serum
        b. Results
            1) High FSH — ovarian failure
            2) Low FSH — hypothalamic — pituitary disease
                skull X-ray
                visual fields
                neurological consultation
                psychiatric evaluation
        c. Treatment
            1) Ovarian failure — sequential estrogen and progesterone
            2) Hypothalamic anovulation — clomiphene and human chorionic gonadotropin
            3) Pituitary anovulation — human pituitary gonadotropin and human chorionic gonadotropin
            4) Treat specific findings — tumors, etc.

define the etiology of the amenorrhea so that one can be more specific in management.

There are certain problems that deserve comment that might be encountered in the original patient work-up, as described above. **Table IV** is an outline of how we evaluate higher areas having an effect on ovulation. If there is evidence of a low estrogen level, such as: no withdrawal bleeding after progesterone therapy, an atrophic smear, atrophic endometrium, or physical evidence of genital atrophy, then further testing is indicated to give the cause. A 24 hour urine for estrogens would be confirmatory. If the pituitary gonadotropins in a 24-hour urine are elevated, it would indicate ovarian failure. At the present time, there is no known successful treatment of ovarian failure when considering ovulation. However, sequential therapy with an estrogen and progesterone can be quite helpful in producing regular menses for these patients and may have metabolic significance.

IF THE PITUITARY gonadotropin test is low, it points to a hypothalamic or pituitary problem. Here skull X-rays, peripheral fields, pneumoencephalograms, a good history, and further neurological evaluation will differentiate the two. Clomiphene is of no value in the treatment of pituitary failure. However, human pituitary gonadotropins along with the use of human chorionic gonadotropin have been quite successful in inducing ovulation in these patients.[9-10] But human pituitary gonadotropin is not generally available. So these patients should be referred to a center for this treatment. Clomiphene can be used in treating hypothalamic causes of anovulation. In this instance, the treatment consists of larger doses followed by the use of the human chorionic gonadotropin. This program has met with success in approximately two-thirds of the patients on whom it has been used.[9]

If the 17 ketosteroids are elevated, then it is necessary to evaluate the adrenal gland. Adrenal suppression tests with dexamethasone* following the 17 ketosteroids and the 17 hydroxycorticosteroids should be used to diagnose adrenal hyperplasias, adrenal genital syndrome, and adrenal tumors, benign or malignant. The specific treatment of these diseases can be very helpful in inducing ovulation. If the 17 ketosteroids are slightly elevated, and if they depress with the dexamethasone suppression test, a trial of cortisone can be very helpful in inducing ovulation. One must be aware, however, that success may not be evident for several months, and if the patient does not respond to cortisone, then clomiphene is the drug of choice. Consideration also must be given to the fact that with polycystic sclerotic ovaries the 17 ketosteroids can be slightly elevated.

Summary

In summary, the drug clomiphene which recently became available, has stimulated renewed interest in the treatment of anovulatory patients. The success is refreshing because it is the first time that a specific ovulatory stimulating drug has been made available. However, it must be used with care, and cautious follow-up of the patient is mandatory. The availability of this drug should also stimulate the physician to better diagnose the cause of the patient's anovulation and to continue the search for a specific diagnosis if clomiphene should not work. ☐

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* Decadron — Merck, Sharp and Dohme

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Insulin Lipodystrophy

This is the first of a series of brief comments concerning problems seen in patients with diabetes mellitus. Members of the Clinical Society of the Michigan Diabetes Association will be supplying this material at frequent intervals. Readers of this Journal who care for diabetic patients will benefit by looking for these presentations of clinical importance and usefulness. — George Lowrey, M.D., Scientific Editor.

BY GEORGE C. THOSTESON, M.D.
DETROIT

Insulin can be disfiguring.

It is not generally realized that a distortion of subcutaneous fat may occur in as many as thirty to forty percent of diabetics taking insulin.

The condition is not serious in that no vital structures are involved but it does create great psychological problems, particularly in females. Insulin lipodystrophy may assume two forms: Lipohypertrophy occurs when a hive-like mass results from the too-frequent injections of insulin into one area; lipoatrophy appears like a saucerization of the tissue, usually occurring at any site of injection. The latter is more common and more disfiguring. It becomes apparent after six months of insulin therapy.

Strangely enough, the occurrence of lipoatrophy occurs primarily in females (young and old) and in little boys. In my experience, it is rare in adult males except in patients with hemachromatosis.

THE CAUSE OF lipoatrophy is not clear. Factors that have been considered include: Trauma from the injection, cold insulin, allergy to insulin, presence of fat splitting ferments in the insulin, preservatives in the insulin (tricresols), protamine zinc, androgens (lack of it predisposing females and young males), and impurities in the insulin. However, none of these factors have been found consistently in all cases.

Based on some of the suppositions as to cause, certain recommendations can be made. Insulin can be kept at room temperature. The currently used ampoule of insulin will not deteriorate at a greater than average rate if not refrigerated. Smaller gauge, longer needles should be tried allowing for a deeper, less traumatic injection. Variation of the site of injection may help. While the arms and legs are the usual sites, the abdomen and buttocks should also be used. In patients with widespread atrophy, it may be difficult to find an area uninvolved. In this instance improvement has been reported by Collens and associates,[1] by continuing to inject the insulin in the atrophic area.

A smaller volume of insulin may be tried by changing from U-40 to U-80 strength. In one case I have advised U-500 insulin measured in a tuberculin syringe and given twice daily. Changing brands of insulin has no effect. Changing to an insulin free from protamine zinc should be considered; globin or the lente group may help.

Gold[2] has injected sterilized coconut oil into the atrophic areas. Improvement was maintained for as long as two and one-half years after treatment.

Changing from beef-pork insulin to pork insulin may help in some instances.

IN SOME INSTANCES lipoatrophy will correct itself in a matter of years. This is little consolation to the woman who is upset by the defect and unable to wear certain summer clothes, shorts or a bathing suit. Lessening of the atrophy tends to occur with gain in weight. This may not be desirable from the medical standpoint nor from woman's sense of vanity.

Lipohypertrophy usually subsides by avoiding injections in the site involved. In my experience, lipohypertrophy can alter diabetic control by reason of faulty insulin absorption. Lipoatrophy does not seem to affect diabetic control. Paley[3] found no change in the stability of diabetic control with this condition.

It is essential to check the sites of insulin injection periodically to determine the presence of lipodystrophy. The thighs should be checked with the legs straight in order to obtain the proper contour. Many women assume a posed position when the legs are examined. This alters the contour of the limb and early changes may not be evident. The arms should be checked in dependent positions to get proper contour of the upper portions where insulin is usually given.

Attempts by the author to control the diabetes of these patients with oral hypoglycemic agents

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Doctor Thompson, the author, is attending physician at Harper Hospital, Detroit.

have not been successful. Usually these patients with lipodystrophy are young with a moderately severe to severe type of diabetes. Such types are generally not amenable to oral agents either initially or after insulin has been tried.

Summary

Insulin lipodystrophy is a complication of insulin therapy. Lipoatrophy is particularly disturbing because of disfigurement and attendant psychological effects. The cause of lipoatrophy is not known.

Patients taking insulin should be examined periodically for signs of subcutaneous fatty changes. □

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Report of Curriculum Study Committee, Wayne State University School of Medicine

The Curriculum Study Committee was appointed in 1963 by Gordon H. Scott, Ph.D., then Dean of the School of Medicine of Wayne State University and now Vice President in Charge of Medical School Development. The Committee was re-appointed by Dean Ernest Gardner, M.D., and with some changes in membership has continued its studies since that time. It was directed to study the curriculum of Wayne State University School of Medicine and make recommendations with a view to meeting the rapidly evolving needs of medical education in a highly sophisticated technological society.

In recent years, the commitments of the University to the State of Michigan led to the expansion of the student body from 65 to 125 per class, and by 1970 the student body will have further increased to 200-250 students per class. Moreover, in 1970, the School of Medicine will move to a new location in a medical center which will include a basic science building that will house multidisciplinary laboratories for the preclinical departments.

In addition to a new medical research building which is already extant, within a few years, the campus will include a new medical library, clinical facilities consisting of a university outpatient building to service all inpatient facilities in the medical center, a children's hospital with 325 beds and teaching and research facilities for children, the Webber-Harper Hospital with approximately 500 teaching beds, the Grace Hospital, the Hutzel Hospital, primarily a maternity hospital with additional facilities for general medical and surgical care, a projected veterans' administration hospital and possibly a new Detroit General Hospital. The Sinai Hospital, an affiliated institution, provides additional well-supervised teaching facilities. The Lafayette Clinic, a state-owned institution, and the psychiatric division of the Herman Kiefer Hospital provide psychiatric facilities.

THE CURRICULUM TO be designated should take into account rapid alterations in the practice of medicine that may be expected within the next decade. The School of Medicine as part of an urban university must prepare for the rapid changes in medical services to be implemented under recently enacted federal legislation that will produce extensive change in systems of delivery of medical care. It must also expect increasing participation by the student body in planning for the educational process to which it is committed. It has become increasingly clear that students in institutions of higher education have become more concerned with the quality of education, medical or otherwise. This we view as a healthy development to be encouraged and fostered.

The Flexner Report published in 1910 precipitated changes in medical education that provided a firm foundation for science in medical education. The extensive and universal development of basic science in medical education was the direct result of this report. The radical changes that are now appearing in medical education and in the practice of medicine are attested to by two of the most significant reports that have appeared in almost half a century, the Coggeshall Report, *Planning for Medical Progress Through Education* published in 1965 and the Millis Report, *The Graduate Education of Physicians* published in 1966. Both reports have emphasized the importance of revision in the medical curriculum.

To quote from the Coggeshall Report, "The medical curriculum currently needs reconsideration, re-evaluation, and revision. The vast accumulation of new knowledge makes it increasingly evident that not all medical information available can be conveyed in four years. There is need to develop a curriculum that provides for later specialization. There is need for re-examination of the curriculum to eliminate both duplication and subject matter not essential to subsequent education and practice. There is a particular need to encourage (medical schools) to give more intensive attention to curriculum evaluation . . . and that more intensified work leading to curriculum improvement be considered. The work undertaken by the association (American Association of Medical Colleges) might include (1) further stimulation of experiments in curricula to adapt to new knowledge, new practices, and new technologies; (2) further efforts to develop better length and sequence to curricula; (3) comparative analysis of results of different curricula; (4) increased exchange of information and discussion about new and revised curricula."

THE MILLIS REPORT states that "because educational programs properly differ from one institution to another, we recommend that each medical school faculty and each teaching hospital staff acting as a corporate body explicitly formulate and periodically revise their own educational goals and curricula. To do so would be a healthy exercise for medical educators and a fundamental step toward the solution of many of the educational problems." The Report proposes certain general goals that need emphasis now. Under educational goals, it recommends that (1) "medical schools and teaching hospitals should prepare many more physicians than now exist who will have the desire and qualifications to render comprehensive, continuing health services, including preventive measures, early diagnosis, rehabilitation, and supportive therapy, as well as the diagnosis and treatment of acute or episodic disease states. (2) No physician, by himself, has all of the knowledge and skills necessary to provide all of his patients with optimal health care. Specialization implies division of responsibility. But the patient is undivided. Programs of graduate medical education should, therefore give greater emphasis to the training of physicians for cooperative effort — among medical specialists and with members of other health professions — in order that each patient may be provided with the combination of skills and knowledge best adapted to his particular needs."

The Coggeshall Report also states that "the important question for the future is whether the present system is sufficiently flexible and imaginative to keep pace with the contemporary revolution in medical science and the changing expectations of the people of America. Specifically, in an era when the concern of society is turning from the protection of the interest of the individual practitioner to finding ways of meeting the aggregate health care needs and expectations of the people of America, the question arises whether new approaches to the education of physicians are not now called for."

CURRICULAR REVISIONS must take into account the following needs stated in the report:

(1) **Need To Devote Increasing Attention To The Requirements Of The Nation.** This need is highlighted by trends toward population growth and change, increasing individual health expectations, increasing effective demand for health care, increasing specialization, need for more physicians and health personnel, and the expanding role of government — virtually all major trends that have been noted. Clearly, the publicly supported medical schools have greater responsibility to orient their efforts toward meeting requirements of their sponsoring states." . . . the need of the future will be for the field of medical education to assume responsibility for meeting the quantitative as well as the qualitative needs of the nation and individual states and communties. . . . increasingly, society is looking to the medical profession to assume responsibility for providing the health care that the scientific advances have made possible and for which members of society desire to pay. . . . Those responsible for medical education — faculty members, deans, university officials, trustees, and legislators — will, in decades ahead, need to devote careful attention to appraising the needs of society for health care and health personnel

and to developing and implementing plans to meet those needs.

(2) Need For More and Better Prepared Physicians. Some factors appear more important to effective instruction than the size of enrollment alone. First, there clearly must be a faculty of adequate size, diversity, and qualifications to serve the school's enrollment. All too often, as a school has increased its enrollment, it has not expanded its faculty and facilities in keeping with the greater instructional tasks assumed. Hence, too limited faculty and facilities have impaired instruction — even though the 'size' of the school has most often been criticized as the cause of a decline in instructional quality. Second, the way instruction is organized will affect how well a school can serve a larger enrollment. On the one hand, adding students without changing the way instruction is organized may well impair the quality of instruction. On the other hand, it is entirely likely that new ways of organizing instruction may overcome traditionally anticipated problems of size and open new possibilities not previously contemplated.

(3) Need For More Persons For Related Health Professions And Occupations. The role of the medical school in the years ahead should be that of seeing that persons needed for related health professions and occupations are trained, that training is appropriate, and that they are trained to participate effectively in the physician-led health care team. The medical school should not, of course, have to assume direct responsibility for their education.

(4) Need To Improve Delivery Of Health Services. The field of medical education needs to turn its attention to the matter of improved delivery of health services in three ways. First, those in the field of medical education themselves need to devote greater attention to studying how health care can best be provided. Second, they need to teach medical students and young physicians to provide health care in the ways that are most effective medically and efficient economically. Third, the medical school of the future can contribute significantly to the health field by providing the 'model' for 'demonstration' of how health care can best be delivered.

Schools of medicine should be taking the lead in studying the ways medical care is delivered to patients. Their concern should be not only with acute care but also with preventive care and rehabilitative care. Their concern should be with comprehensive family care as well as with specialty care. The university-sponsored medical school is in an unequalled position to draw on the resources of many disciplines — medical practice, economics, business administration, sociology, psychology, education, engineering, and others — to study the way in which comprehensive health care is provided. The need is for careful study of how health care can best be made available including how medicine can best be practiced — and for the development of more effective plans of organization and delivery of health care.

(5) Need To View Medical Attention As A Continuum. Although some schools are doing some planning, there are too few. Those that do are

Editor's Note: This WSU Curriculum Study Committee report is printed because it is believed that many MSMS members will be interested. The report has been approved in principle by the entire medical school, but not all the changes have been incorporated as yet into the curriculum. The Curriculum Study Committee was comprised of Ruben Meyer, M.D., Chairman, Harry Maisel, M.D., Secretary, Donald J. Birmingham, M.D., Lawrence Powers, M.D., Barbara F. Rosenberg, M.D., Kenneth Pitts, M.D., Alexander J. Walt, M.D., Lawrence M. Weiner, M.D., and Joseph Hess, M.D.

doing too little; the need for planning can be expected to increase rather than decrease in the future.

The educational needs of the physician should be re-evaluated, toward the goal of defining the subject matter which should be included in the curriculum. It should be recognized that the physician can no longer master all areas of the basic biomedical sciences — he cannot even be acquainted with all of them. Nor can he be competent in all technologies associated with his own specialty. He must be increasingly dependent upon personnel trained in related fields. The education of a physician must more and more include management and *problem solving rather than encyclopedic capacity*. No longer is the individual physician with his personal armamentarium of knowledge and tools, the patient's sole resource. The physician must now assume the role of team leader having the broad familiarity and competence to marshal the appropriate expertise and resources beyond his individual skill. This ability to use technical assistance and to work cooperatively in a team should be the essence of professionalism. Basic principles required for intelligent decision making should compose the curriculum, with emphasis placed on problem solving and the use of human and technological resources.

(6) Need To Maintain Interdisciplinary Relationships And Relationships Between Research And Instruction. Prevailing trends imply clearly that a dynamic relationship will need to be maintained permanently between research and instruction.

Closer ties among the sciences and closer ties — virtual identity — between research and instruction highlight the need for further development of the relationship between the medical school and the university emphasized by Flexner a half-century ago.

(7) Need For The University To Assume Increasing Responsibility For Medical Education. Curricula should be interwoven to provide a community of mutual understanding among all health-oriented disciplines, and the programs of each specialty should include direct experience in how to function as a member of a cooperative team.

The educational obligations of the School of Medicine must be assumed by the medical faculty and a system of educational goals should be designed to meet its educational responsibilities. Appropriate evaluation procedures will have to be established to test the effectiveness of the system.

The faculty of the School of Medicine must clearly understand that the student is the prime subject of its educational efforts. The entering student is strongly motivated to become a physician with a desire to help others and be of service to society but is frequently converted to a frustrated individual.

Local Problems

Some of the problems of the current teaching program at our School of Medicine are as follows:

(1) The curriculum is inflexible. Every student must tread the same mill in its entirety.

(2) The curriculum is largely uncoordinated with respect to individual disciplines, and between basic sciences and clinical medicine.

(3) Teaching is often academically unrewarding to the faculty and secondary to research needs; this frequently leads to inadequate teaching.

(4) Basic science departments often fail to consider the goals of their teaching programs with respect to the student's motivation of becoming a physician. Instruction is frequently "all-encompassing," a cramming of newer knowledge into the same hour of instruction without the pruning of older material. It appears that instructors are at times afraid to entrust students with the process of self-learning, but endeavor to cover all aspects of a subject.

(5) There is a minimum of patient contact in the first two years.

(6) Little, if any, time is spent on remedial exercises for students with learning problems. The drop-out rate at medical school represents an important wastage of manpower and money, and is often the result of a student's poor "cramming" technique rather than lack of intelligence.

(7) Examinations are held so often and in such a manner that they lead to an inhibition of independent thinking and scholarship.

To remedy these defects the Curriculum Study Committee proposes that the medical school *should, in its primary function of training physicians, provide an educational experience that*

(1) Encourages scholarship and independent thinking and leads to the acquisition of a scientific attitude and the habit of continuing self-education;

(2) Furthers the motivation of entering students to be of service to man and society; and

(3) Is flexible to meet the needs of individual students. These needs arise from differences in student background, interests, and choice of future medical careers.

These aims can be accomplished by:

(1) Teaching a "core curriculum" in the basic science by an interdisciplinary method, and using an organ system approach.

(2) Implementing a core clinical experience, with greater interdepartmental participation.

(3) Introducing elective courses.

(4) Providing adequate free time for independent study.

(5) Introducing correlative clinics in the first year to emphasize the relevance of the basic sciences to clinical medicine.

(6) Commencing instruction in the technique of history taking and physical examination from the beginning of the second year.

(7) Indicating the relevance of behavioral science and socio-economic factors to health and disease.

(8) Providing individual student counselling, and

(9) Consideration of an honors program for gifted students.

> ***"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."***
>
> *—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs*

MSMS ANNUAL SESSION, SEPT. 25-26-27

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House of Delegates, Sept. 22-23-24

A Progress Report: The Michigan Community Health Services Study

BY ANNA B. BROWN, PH.D.

AND VLADO A. GETTING, M.D., DR.P.H.

ANN ARBOR

Do committee reports on health problems result in action or gather dust on a shelf?

The Committee of Forty of the Michigan Community Health Services Study[1] believes that action can result from study reports and began exploring the opportunities and possibilities at their March, 1968, meeting at Fair Lane Conference Center, University of Michigan Dearborn Campus.

During June and July, the Study's six Regional Task Forces on Community Health Services will meet to review the Committee of Forty report of recommendations, and to determine priorities for implementation based on this report and on their own regional reports.

THE STUDY DEMONSTRATES that concerned citizens, community leaders, are interested in health services and facilities. They can and will work with health professionals in order to effect the improvement of health services in Michigan. The reports of recommendations are one step in this process; implementation of the recommendations is another step.

Among the recommendations covering a broad spectrum of problems, are areas of current interest and concern to medical societies; for example,

1. Codification of all health laws, rules and regulations,

2. Provision of emergency mental health services,

3. Determination of need and development of drug addiction programs,

4. Treatment and rehabilitation of alcoholic patients,

5. Provisions for ambulance service,

6. Improvement of health instruction in the Michigan school systems,

7. Communication of health services and resources to practitioners and consumers, and many others.

The reports and the forthcoming meetings are a culmination of four years of effort of 246 community leaders who were members of the six regional task forces and the statewide committee. These leaders identified public health programs, consulted with experts, reviewed resources and existing programs, considered alternative solutions, and then developed recommendations for the improvement of community health services. Each of the six task forces prepared a report. These reports were then reviewed and together with its own recommendations, consolidated into a single report[2] by the statewide committee.

THE INVOLVEMENT OF community leaders began in 1963 when the Michigan Community Health Services Study was initiated under the sponsorship of the Department of Community Health Services of the School of Public Health of the University of Michigan; the Michigan Department of Public Health; and the Michigan Health Officers Association. Representatives of the sponsors shared a growing concern that community health needs were not being adequately met by traditional patterns of organization and financing. Out of their concerns, the plan for the Study evolved and was financed by grants from the W.K. Kellogg Foundation and the United States Public Health Service.[3] Operationally, representatives of the sponsors formed a group, the Research Policy Committee, to give direction and guidance to the work.

The State was divided into six regions taking into consideration: 1) health department boundaries, 2) hospital service areas, 3) trade centers, 4) travel patterns, 5) natural geographic boundaries, etc. Each region was composed of several counties (7 to 28) and a population ranging from

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Anna B. Brown, Ph.D., is Research Associate and Lecturer, Department of Community Health Services, School of Public Health, University of Michigan and staff member, Michigan Community Health Services Study.

Vlado A. Getting, M.D., Dr. P.H., is Chairman, Department of Community Health Services and Professor of Public Health Administration, School of Public Health, University of Michigan and project director, Michigan Community Health Services Study.

TABLE I

CHARACTERISTICS OF REGIONS IN THE STUDY

REGION	NUMBER OF COUNTIES	POPULATION	PER CENT STATE POPULATION
I Upper Peninsula	15	305,952	3.9
II Northern Michigan	28	355,614	4.5
III Southwestern Michigan	9	1,148,552	14.7
IV Central Michigan	10	760,367	9.7
V Detroit-Southeastern Michigan	7	4,181,384	53.5
VI Saginaw Valley-Eastern Michigan	14	1,071,355	13.7
Total	83	7,823,194	100%

305,952 in the Upper Peninsula, Region I, to 4,181,384 in Southeastern Michigan, Region V. **(See Table I)**

Community leaders in each of the 83 counties and for the whole state were identified using an adaptation of the methodology employed by the National Commission on Community Health Services.[4, 5]

Briefly, one questionnaire was mailed to the health officers, or the public health nurse or sanitarian if there was no health officer. Another questionnaire was then sent to certain positionals in each county, i.e., persons holding various positions in sectors of society such as the president of a large bank, the president of the local medical society, the editor of the largest newspaper, the superintendent of schools, and so on. Positionals and health officials were asked to complete the questionnaire by identifying: 1) persons who had been involved in decisions on community issues such as annexations, civil rights, fluoridation, local income tax proposals, etc.; and 2) those individuals who were considered to be persons of general influence. The nominees, resulting from the analysis of questionnaires, were classified into sixteen sectors of society such as physicians, businessmen, bankers, labor leaders, educators women's groups, mass media. **(See Table II)**

From the resulting listings, according to predetermined scoring techniques, approximately 75 percent of the membership of each task force was selected. Representatives of the three sponsors and local health officers, using their knowledge of persons in the region, selected the remaining 25 percent of the task force members. The latter group was added to assure both geographical and occupational representation.

TABLE II

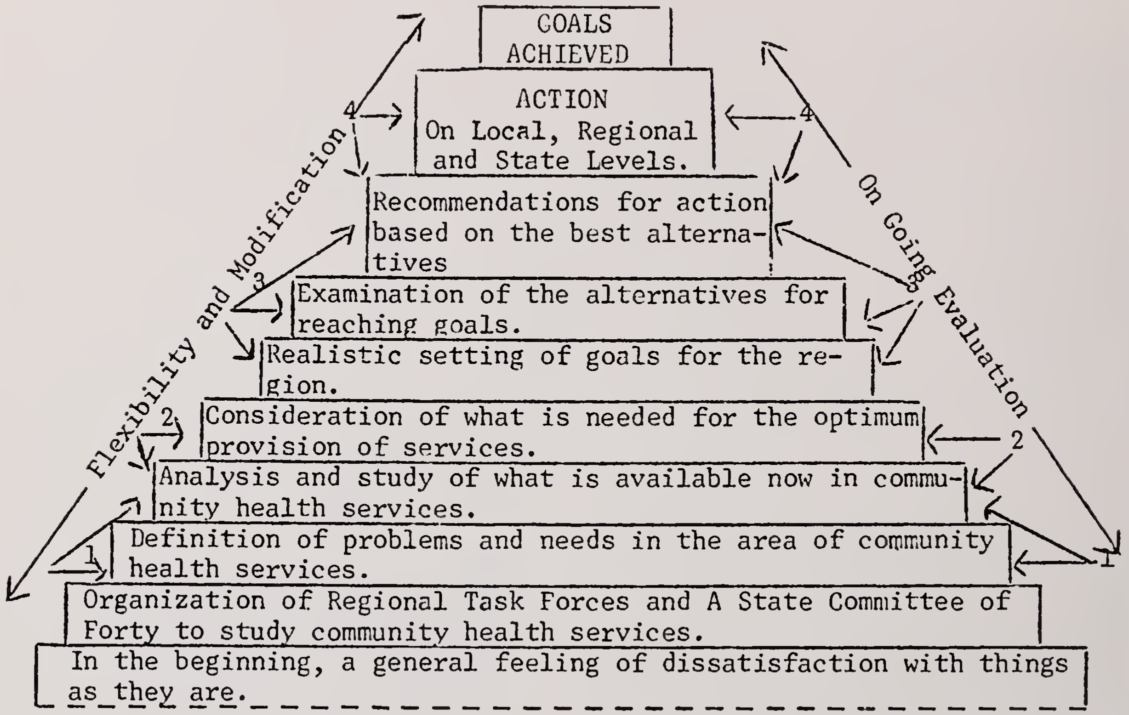
PARTICIPANTS, BY OCCUPATION, IN TASK FORCES AND COMMITTEE OF FORTY. (See also page 618.)

1. Twelve members of the Committee of Forty are the representatives of the Regional Task Forces so must be counted only once in the totals.
2. "Task Force Studies Include Physicians," *Michigan Medicine*, Vol. 65, No. 5, May, 1966, p. 346. C-40 physicians not named in article.
3. Included farm leaders.
4. Other than health and welfare.
5. A Regional Mental Health Coordinator serves both Regions I and II and is counted as a member of both Regional Task Forces; therefore, is counted only once in the grand total.

Table II shows the occupation of participants in the task forces and the statewide committee.

THE FIRST TASK force was organized in July, 1965, in the Upper Peninsula of Michigan. Gradually, the other task forces were organized in the remaining five regions of the State. It was the plan to have approximately 40 persons on each task force; the final membership ranged from 30-44. One research associate was to serve as staff for two task forces. The entire study staff (three associates serving six regions; an assistant director, who staffs the statewide committee; a sociologist, who serves as the process analyst and evaluator; three secretaries and a part-time research as-

DIAGRAM FOR ACTION IN COMMUNITY HEALTH SERVICES


GOALS ACHIEVED
ACTION On Local, Regional and State Levels.
Recommendations for action based on the best alternatives
Examination of the alternatives for reaching goals.
Realistic setting of goals for the region.
Consideration of what is needed for the optimum provision of services.
Analysis and study of what is available now in community health services.
Definition of problems and needs in the area of community health services.
Organization of Regional Task Forces and A State Committee of Forty to study community health services.
In the beginning, a general feeling of dissatisfaction with things as they are.
Flexibility and Modification
On Going Evaluation
1
2
3
4

(STATISTICS RELATED TO TABLE II)

OCCUPATION (Generalized Category)	REGION						C/40[1]	TOTAL
	I	II	III	IV	V	VI		
Physicians - Osteopaths	1	4	2	-	4	3	4	17[2]
Bankers	1	-	-	1	1	1	2	6
Businessmen	2	3	3	4	5	4	4	24
Industrialists	1	3	2	1	3	3	2	15
Labor Leaders	1	-	1	3	-	1	1	7
Elected Officials[3]	6	9	5	8	7	6	4	43
Government Employees[4]	1	6	8	3	4	3	2	25
Educators	8	6	2	4	3	6	11	37
Church Representatives	2	2	1	1	1	-	2	8
Lawyers - Judges	3	1	-	1	1	-	-	6
Health	2	4[5]	3	2	2	3	4	17[5]
Welfare	2	1	1	1	2	1	3	11
Women's Organizations	3	-	2	-	4	1	-	10
Mass Media	1	4	1	1	3	-	2	12
Dentists	1	1	1	-	1	1	1	6
Opticians & Pediatrists	-	-	1	-	1	-	-	2
TOTAL	35	44	33	30	42	33	42[1]	246

sistant) was housed in University facilities in Ann Arbor. The Chairman of the department of community health services is director of the Study; The University of Michigan, the administrative agent. In addition, staff of the Michigan Department of Public Health and local health departments serves as consultants and resource people.

The first meeting of each task force stressed member identification of community health problems, and the fact that task forces would not be asked to rubber stamp or lobby for any predetermined program.

Each task force in collaboration with its staff consultant adopted a procedural model, diagrammed on page 618.

Task Clarification

Ultimate Goal — To assure communities throughout Michigan of the effective and efficient delivery of high quality health services which are readily available to all communities.

Task Force Goal — To study, to identify health problems, to consider solutions, to develop plans for the organization and financing of health services, and in the final analysis, to assist in their implementation.

Four Basic Questions

1. What is the present state of affairs in community health services?

2. What are the apparent weaknesses — these considered in relation to goals?

3. What steps should be taken to improve community health services (alternatives considered)?

4. What is desirable to implement the steps?

Community health services are so broad that a second model was developed to divide the Study into four manageable components. See page 618.

An Approach To The Task

Based on the definition of community health services, put components into four broad groupings:

1. Local health departments and State department of public health

2. Other official agencies (welfare, mental health, agriculture, education, water resources, etc.)

3. Voluntary agencies

4. Medical facilities and services (hospitals, nursing homes, home care, medical care facilities, etc.)

Considered beyond the purview of this Study were the quality of in-hospital services and physician-patient relationships.

For each component and each part of the component ask these three questions.

1. Who does what, how? (personnel, services, programs, administration)

2. How is it organized to perform functions?

3. How is it financed?

As each component is studied, ask how all components are interrelated and coordinated.

Rapidly the regional task force members became involved in the study and analysis of community health services in Michigan. For the first time, there was a continuing opportunity for the discussion of health issues on a regional basis. The developing interest and concern of the task force members was demonstrated by their attendance at meetings, identification of health problems, review of fact sheets sent to their homes and offices, analysis of data, and finally, in the formulation of recommendations for action—the regional reports.

A statewide Committee of Forty was created using the same method as was used in selecting task force members except that each task force had two representatives and two alternates on the statewide committee. In addition State governmental agencies, professional societies and large voluntary agencies were requested to send consultants to meet regularly with the Committee. From time to time, the members of the sponsors' Research Policy Committee attended meetings. Thus, ample opportunities were available to give professional guidance and advice to the community leaders who comprised the task forces. The Committee of Forty considered statewide health needs and problems, and within this context, reviewed and consolidated the recommendations flowing from the regional task forces.

Since this task is completed with a final critique and review in March, 1968, the Committee of

Forty and the regional task forces are exploring ways and means to implement those recommendations which they perceive to be both very important and amenable to action within a reasonable time.

PROGRESS TOWARDS implementation is just beginning to unfold. A cadre of community leaders and health professionals have participated in comprehensive studies and plans to improve regional and statewide health services. Implementation plans must depend upon the concerted effort of all professional groups as well as citizen leaders and civic groups.

The Committee of Forty report of recommendations will provide a starting point in planning for action. Copies of this report may be obtained from the Michigan Community Health Services Study, 122 South First Street, Ann Arbor, Michigan 48108, after May, 1968. ☐

References

1. "New Study to Survey Health Needs," *Michigan Medicine*, Vol. 64, No. 9, Sept. 1965, p. 719.
2. The provisional report of this committee, The Committee of Forty, was given final consideration at the March, 1968, meeting.
3. Project Grant CH 24-11, USPHS.
4. *Action-Planning for Community Health Services.* Report of the Community Action Studies Project, National Commission on Community Health Services, Public Affairs Press, Washington, D.C., 1967.
5. Wilson, Robert N., *Process Analysis: A Study of Community Structure and Health Action.* Public Affairs Press, Washington, D.C., 1967 (in Press).

Offer Four Day-Long Courses At 1968 MSMS Annual Session

A new feature during the two-day annual MSMS Annual Scientific Session, Wednesday and Thursday, September 25-26, at the Sheraton-Cadillac Hotel in Detroit, will be four, day-long postgraduate courses in "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases," and "Difficult Decision in Digestive Diseases."

The Wednesday, September 25, courses on "Infectious Diseases" and "Pulmonary Diseases" will run simultaneously from 9:00 AM to 5:00 PM. Each course will involve approximately six hours of in depth discussion and presentation.

Martin A. Lerner, M.D., professor of medicine at Wayne State University Medical School and chief of infectious diseases at Detroit General Hospital, is moderator for the course on "Infectious Diseases." He announces that the course will be devoted to advances in virus diagnosis and therapy, including vaccines and chemotherapy, and advances in anti-bacterial usage.

"Blood Diseases" and "Difficult Decision in Digestive Diseases" will be held on Thursday, September 26.

All courses are limited to 45 persons; cost is $10 per course.

Advance registration is essential because of limitation of space.

Michigan Medicine will print further course information as it becomes available.

COMMITTEE ROSTERS AVAILABLE FROM MSMS

Physicians who are interested in obtaining copies of the MSMS committee rosters can get them from MSMS Headquarters, P.O. Box 152, East Lansing 48823.

KENT CONFERS WITH LEGISLATORS

The Kent County Medical Society has an ambitious, successful pattern of hosting their legislators each week for a luncheon session. Shown here at a typical session are, standing left to right, Senator Robert Vander Laan, Grand Rapids, 31st District; Kornelius Van Goor, M.D., Kent County Medical Society; Fred C. Brace, M.D., Kent County Medical Society; Frederick S. Gillett, M.D., Kent County Medical Society; James A. Ferguson, M.D., Kent County Medical Society; Gerald Vander Voord, M.D., Wayland, representing Allegan County Medical Society; J. Jay Post, M.D., Allendale, representing Ottawa County Medical Society. Seated, left to right, are Joseph C. Kolderman, Jr., Grand Rapids, Representative 94th District; Martin D. Buth, Comstock Park, Representative 90th District; Charles E. Farber, M.D., President, Kent County Medical Society; James S. Farnsworth, Plainwell, Representative 55th District; Melvin DeStigter, Hudsonville, Representative 95th District; John R. Wilson, M.D., President-Elect, Kent County Medical Society; Mrs. James T. Klomparens, Grand Rapids, representing Woman's Auxiliary of Kent County Medical Society.

Swanson Asks Viet Med Aid

"Right now we need to fix the wounds of the people of South Vietnam, but we also need a long range medical training program to help them take care of themselves," said Alfred Swanson, M.D., of Grand Rapids, when he appeared before the House Foreign Affairs Committee in Washington on April 11.

Doctor Swanson presented a 23-point plan relating to medical care of South Vietnamese civilians.

He called for a dramatic increase of the present AID budget, which stands at $26.1 million for fiscal 1968, to at least $500 million for the next three years.

A major point in Doctor Swanson's proposal was that American military physicians serving in South Vietnam should be made directly responsible for civilian medical care. "At present," he said, "the South Vietnamese do not have the capacity to cope with their immense medical problems so we must fill the gap."

He also spoke to the committee on the large role which medicine can play in International Affairs.

Arrangements for the testimony were made by Thomas E. Morgan, representative from Pennsylvania, chairman of the Foreign Affairs Committee, because of a request from Representative Gerald Ford, House minority leader from Grand Rapids.

MSMS President-Elect James J. Lightbody, M.D., third from left, reviews the notes from the recent MSMS conference on quackery with leaders of the three workshop-discussion groups. The leaders, left to right, were Joseph H. Shaffer, M.D.; Otto K. Engleke, M.D., and Harry A. Towsley, M.D., at right.

One of the discussion groups studies the many AMA publications against quackery, which are being used by physicians and civic groups in educational efforts. Holding the exhibit are Harry A. Towsley, M.D., left, and Phil O. Pittinger, Lansing, member of the Michigan House of Representatives.

Representatives of Many Groups Help MSMS Seek Ways to Stop Quacks

"Death, fraud, theft — these are prices Americans pay to health quacks, reports the Michigan State Medical Society."

So declared a syndicated news article that appeared across the state following the one-day MSMS-sponsored conference at the MSMS headquarters recently for attorneys, legislators, state police, members of the attorney general's staff, civic leaders and physicians.

The syndicated article explained that "in terms of death, it is estimated that more Americans lose their lives each year to quackery than to all crimes of violence put together. In terms of dollars, the take approaches $3 billion a year, with more than $100 million in Michigan alone." The extensive report on the conference was sent to all Michigan papers by Elmer E. White, executive director of the Michigan Press Association.

Maurice M. Moule, fourth from the left, was one of the several members of the State Attorney General's staff who assisted in the conference by interpreting present laws and by discussing problems in enforcement of the present fraud regulations.

THE CONFERENCE was called by MSMS to discuss possible methods of combatting health quackery in Michigan. Recommendations from the conference are being studied by The MSMS Council now.

The Lansing *State Journal* reported the event in an article with the positive headline of "Medics Open Drive Against Quacks." The article, in part, declared that MSMS "called for concentrated effort in ridding the state of so-called health quacks."

MSMS President-Elect James J. Lightbody, M.D., set the stage when he explained that the representatives of the many groups were convened so "we could put our collective experience and thinking together to determine whether we can effectively curb health faddists and fakers in Michigan."

THE PARTICIPANTS QUICKLY agreed that a legal definition of a "quack" is needed in Michigan. The group studied the new California law

Continued on Page 623

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THANKS DR. HAYES

Louis F. Hayes, M.D., right, received a special citation from the Michigan State Medical Society at the recent Michigan Health Planning Conference in Detroit. Vernon V. Bass, M.D., Saginaw, left, presented a framed resolution adopted by the MSMS House of Delegates thanking Doctor Hayes for his four years of service as Vice-Speaker of the House of Delegates. The resolution lauded Doctor Hays for his "diligence and perception" in presiding over many business meetings. Doctor Hayes resigned the office when he accepted an administrative position with Michigan Blue Shield. Doctor Bass is the new Vice-Speaker.

MSMS Lists 9 PG Programs Week of May 13

The greatest number of MSMS Spring Postgraduate Programs will be during the week of May 13. During that week eight will be held in the Upper Peninsula with two teams of doctors covering the miles, and another will be in Muskegon.

The PG seminars began April 11 in Petoskey. The last will be held May 23 in Cadillac.

Many of the programs include a clinic at a local hospital in the afternoon, followed by a formal evening program.

The spring postgraduate program, being held in 19 cities around the state, is sponsored by MSMS, the Michigan Department of Health, Michigan State University, the University of Michigan, and Wayne State University.

Chairman of the Committee on Postgraduate Medical Education is Harry A. Towsley, M.D., of Ann Arbor.

Serves in Vietnam

Donald Lipsey, M.D., a general practitioner from Durand, has joined the ranks of the AMA Volunteer Physicians for Vietnam. Doctor Lipsey will return from South Vietnam at the end of May.

ANTI-SMOKING POSTERS OFFERED

A striking poster which reads "1,000 Doctors Have Quit Smoking Cigarettes (Maybe they know something you don't)" is offered by MSMS and the Michigan Council on Smoking Health to MSMS members for their offices.

Any physician who would like to receive one, or a supply of them, can get them from MSMS Headquarters, P.O. Box 152, East Lansing.

DETROIT ART SALE TO AID DPI CENTER

Bruce L. Danto, M.D., director of community psychiatry at the Detroit Psychiatric Institute, announces an art show and sale Thursday through Saturday, May 9-11, at the Northland Center Community Arts Building. The show will be sponsored by the Phi Delta Epsilon medical fraternity.

Purpose of the sale is to raise funds to establish a Suicide Prevention Center at the Detroit Psychiatric Institute. This will be the first such center in Michigan. The show will feature original oils and sculpture by local and foreign artists.

For further information on the show, contact Mrs. Milton Simmons, 18658 George Washington Road, Southfield, Mich. Tel: 356-3184.

CONTINUED: Help MSMS Seek Ways to Stop Quacks

which makes "quackery" a felony, punishable by imprisonment for up to 10 years.

All agreed that education and publicity are paramount in the battle against quackery. Recommendations were offered that educators should develop study units that would inform students about the dangers of quackery.

CONSIDERABLE INTEREST was shown in a suggestion that an agency be established to receive complaints from persons who believe they've been taken in by quacks — and that such an agency investigate and move towards court action. It was recognized that prosecution is often difficult because victims do not want to sign complaints. "Some are too embarrassed; some are dead," the newspaper accounts related.

The MSMS activities in the quackery-education field were suggested by the MSMS Committee on Public Relations. An afternoon quackery conference was part of the First Annual Conference on Michigan Health Planning held recently in Detroit. Other activities will be carried out under the direction of The MSMS Council.

MAP Capitol Trip Includes MSMS Leaders

Several Michigan physicians took part in the recent three-day Washington legislative trip sponsored by the Michigan Association of the Professions.

Attending were Gilbert B. Saltonstall, M.D., of Charlevoix, president of MAP; Bradley M. Harris, M.D., Ypsilanti, president of MSMS; James J. Lightbody, M.D., Detroit, president-elect of MSMS; Robert J. Mason, M.D., Birmingham, chairman of The MSMS Council; and Vernon V. Bass, M.D., Saginaw, MDPAC Chairman.

One of the highlights was the Congressional Breakfast April 30 at the Rayburn Building. MAP dignitaries and other invited guests met with a number of Michigan legislators for informal discussion.

Other highlights on the agenda were congressional visitations, trips to both the Nixon and McCarthy campaign headquarters, and visits with Senators Morton and Dirkson.

Michigan State Medical Society

OFFER BOOKLET RE MSMS STAND

MSMS members interested in obtaining a copy of "Where Does MSMS Stand?" are invited to write to Hugh W. Brenneman, Executive Director, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. The chapter on "Civic and Community Affairs" is reprinted on 662-663.

DPS MEETS MAY 16

The annual lecture of the Detroit Physiological Society will be delivered by Bruce H. Stewart, M.D., of the Cleveland Clinic. His presentation will be made at 8 p.m., May 16, at the headquarters of the Wayne County Medical Society.

Did You Read Anderson Article?

Attention is called by the Publication Committee to the *Michigan Medicine* April article about "The Medical Profession and the Public: An Examination of Interrelationships."

The article is the third in a series of original papers commissioned by the MSMS Committee on Medical Socio-Economics, Dale L. Kessler, M.D., Grand Rapids, chairman. The others were "The Outlook for Group Practice-Payment, Direct Service Plans during the Next 20 Years," by Caldwell B. Esselstyn, M.D.; and "The Future of Health Insurance, Prepayment and Medicine" by Charles P. Hall, Jr. The article by Temple University Professor Hall was later judged by the National Blue Shield organization as the most scholarly article printed in any medical publication during 1967 about socio-economic issues.

The Publication Committee welcomes comments on the third article by University of Chicago Professor Oden Anderson in the April issue.

PLAN DISTRIBUTION OF MEDI-LABELS

A new study is now underway by the MSMS Committee on Highway Injury to determine what responsible lay groups would be interested in the distribution of Medi-Labels. A letter will be sent to various groups explaining the value of the project and inviting their participation in the distribution of the labels to their membership. It will be clearly emphasized that every individual receiving a sticker must take it to his physician to have the proper medical data recorded on it.

Approximately 10,000 MSMS Medi-Labels have already been distributed to physicians. Requests for Medi-Labels have come from a large Michigan lay health group and from a woman's service organization, and it is anticipated that the expected interest from other lay organizations will result in 200,000 more persons carrying the sticker attached to their driver licenses.

Kidney Disease Symposium, May 24-25

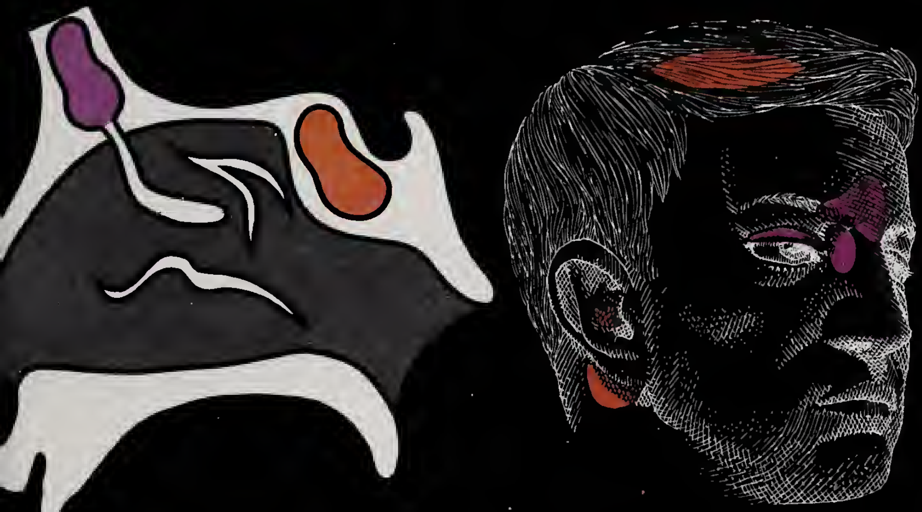
New medical knowledge about home treatment with the artificial kidney will be reported to physicians at the Seventh Annual Michigan Kidney Disease Symposium in Grand Rapids.

Sponsored by the Michigan Kidney Foundation, a United Community Services agency, the event will be Friday and Saturday, May 24 and 25 at Xavier Hall in St. Mary's Hospital.

TREATMENT OF INJURIES TOPIC FOR U-M WORKSHOP

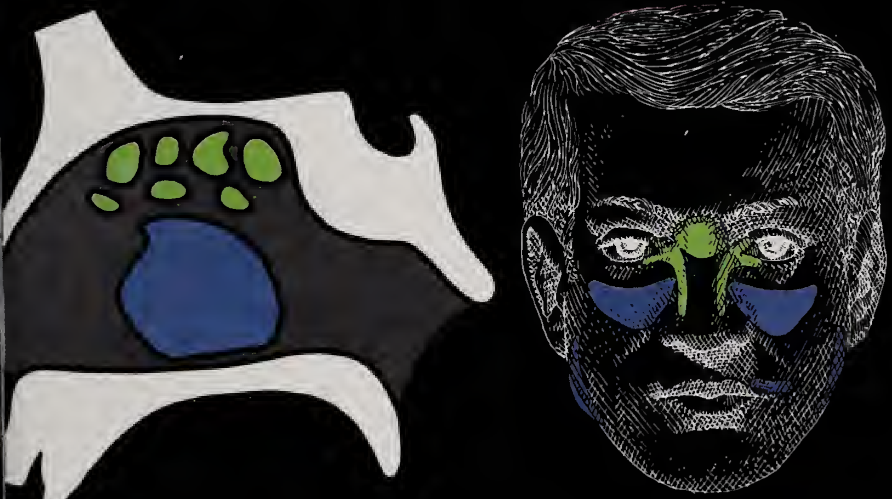
Physicians and others interested in the subject are invited to the Third Annual Conference on the Initial Management of the Acutely Ill or Injured Patient, May 15-17, at the University of Michigan. The conference is sponsored by the Medical Center, the Extension Service, and the Highway Research Institute.

Sources of sinus headache

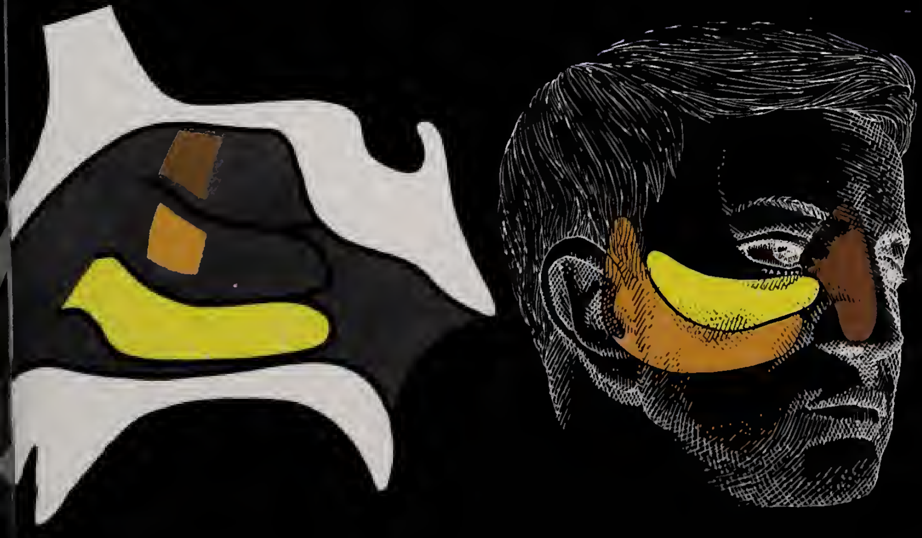


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. Sinutab *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA

SINUTAB®

FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

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AMBULANCE SERVICE
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RESCU
SQUAD

Bedford Rescue Squad Ambulance arrived on the scene of this automobile accident just four minutes after the report of an emergency came into their office. The accident happened on a rural road, two miles from the ambulance garage. (Photo by John Boughton)

A Rural Editor Looks At Emergency Medical Service

BY JOHN BOUGHTON, EDITOR
NASHVILLE NEWS

Seven men sat around a table in the village of Nashville, Michigan a few days ago to discuss ambulance service in that small community. The purpose of the meeting was to hammer out some sort of a proposal to present to the county board of supervisors. The supervisors, in turn, are concerned with keeping their county covered with ambulance service.

The Nashville dialogue is in no way unusual. Small communities all over the state, faced with the decision of many funeral directors to no longer provide ambulance service, are attempting to solve this problem.

The Nashville group consisted of two township supervisors, two volunteer firemen, a township clerk, a newspaper editor and the local funeral director. These men were all deeply concerned with this one aspect of rural emergency medical service.

ASIDE FROM THE funeral director, who has agreed to continue to provide ambulance service until some other arrangements can be made, none of the people working on the medical problem was really professionally involved. Their sole interest was in doing what they could to solve a problem, a problem which they obviously feel is not particularly resting on the shoulders of the medical profession. They treated this as a problem of the community as a whole.

The people of Michigan's rural communities are deeply concerned with the problem of rural emergency medical service. Their handling of this one phase of rural emergency medical service, rural emergency ambulance service, is evidence that they want the utmost in this service and they are willing to do their part to see that it is provided.

The question that immediately arises is, How extreme is the problem? Are we of Michigan's rural communities really lacking in emergency medical service?

Of course, the answer is relative.

Hunger, to the American schoolboy who rushes into a well-stocked modern kitchen, starving to death, to manufacture for himself a king-sized peanut butter and jelly sandwich, is altogether different from the hunger of a child in India, who is indeed starving to death.

RURAL EMERGENCY MEDICAL care is really, in Michigan, a relative problem. Compared to other parts of the world, compared to many other states in the United States, our problems of rural health care are infinitesimal.

Yet, ideally, if one person is in need of emer-

Continued on 631

She relies on your contraceptive advice

She can expect to continue Oracon for years

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

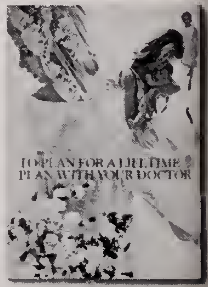
observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with Oracon has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of Oracon usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

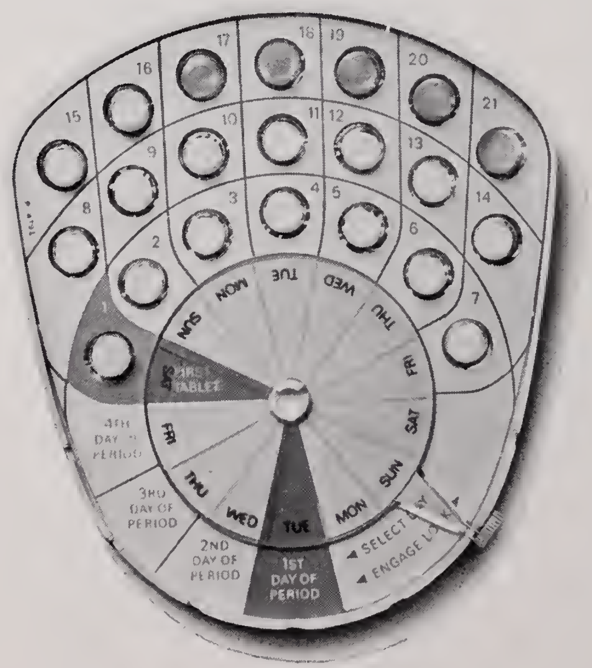
Availability: Oracon is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on Oracon are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.



The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.



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gency health care and does not get it immediately, there is a problem in Michigan.

Perhaps compared to the emergency medical health care in the cities, at least in some respects, the rural areas are left wanting.

By the very nature of our rural communities, though, the solution to the problem may be simplified.

The smaller rural and suburban communities seem to have retained yet some of the fast-fading frontier traditions that were their heritage. This frontier tradition involves, not only doing what one can for himself, but also doing what one can for one's neighbors who may be in an emergency situation and needs immediate assistance.

This is pointed up very dramatically and often in a small rural community.

Recently, on a very cold morning, fire completely destroyed a large barn near the village of Vermontville. The members of the completely volunteer rural fire department were routed out in the early sub-zero dawn to fight the fire. Neighboring farmers showed up immediately to assist where they could. Neighboring farm housewives were in the kitchen with pots of coffee and rolls almost as soon as the fire trucks were in the yard.

There seems to be less of an air of detachment in the rural community. The "I don't want to get involved" attitude appears less prevalent.

THE ATTITUDE OF togetherness in the small rural community include the physician as the town seeks to solve emergency medical service problems.

The small town physician is known by just about everybody in the community and is a leader in the community.

The people in the urban areas are used to throwing emergencies on the shoulders of the local police. This often includes even emergency medical problems. The police department is the proper agency to handle such things.

Not so in the rural area. Here the middle man is likely to be bypassed. At a street accident in a farming or a rural community where there appears to be serious physical damage, the cry is immediately, "Get a doctor!" and more often than not a specific doctor will be named for the duty. The physician thus becomes the agency to initiate official handling of the episode.

There is little doubt that rural emergency medical service is a problem, relative though it may be. A study of rural and urban traffic fatalities in California showed that one and one-half times as many people were injured per one thousand population in traffic accidents in rural counties (under 50,000 population) as contrasted with urban counties (over 500,000 population).

The California study also showed that people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries. The higher case fatality ratio in rural areas seemed to be related to the inability to provide adequate first aid procedure and to get the person to a hospital within a reasonable period of time, according to the California study.

ROBERT E. RICE, M.D., Greenville, chairman of the MSMS Rural Medical Services Committee, reduces the problem to its least common denominator when he says that distance to the hospital and time seem to be the important factors here. Doctor Rice points out that in the case of many rural accidents, a relatively long period of time passes before the acciddent is known to those other than the ones involved and the proper help can be obtained. Often the remoteness of an accident on a farm greatly adds to this time factor.

In a case of a tractor which tipped on a child, it was almost 15 minutes before a survivor of the accident could get to the closest telephone and several more precious minutes before the tractor could be tipped up and the child removed from under it, then several minutes more to transport the patient to the nearest hospital.

Doctor Rice is of the opinion that the important factors in the problem at hand are:

1. Time

Continued on 632

The Bedford Ambulance Squad answered 1150 calls last year, many of them traffic accidents on rural roads. (Photo by John Boughton)

AMBULANCE
DODGE

2. Availability of the properly trained help for the victim.
3. Availability of proper and adequate equipment to take care of the emergency.

It probably comes as no great shock to anyone to hear that studies also show that farm workers have an unusually high accident-death rate. The Council on Rural Health of the American Medical Association says that 760,000 farm people are disabled every year in accidents on the farm. Only people who work in mines or on construction jobs have a higher accident-death rate.

These statistics would make it appear obvious that there is much to be done in the field of rural emergency medical service.

The picture is not at all bleak. Much is being done and what remains to be done can be accomplished through the cooperation of local legislative bodies, the general public, schools, farm organizations with the hospitals and physicians.

THE PECULIARITIES of the rural community, some of which have been pointed out, should make an attack of the problem less difficult than it might be. The awareness of official bodies and the general public of the problem and the willingness of the general public to help solve the problem should ease the burden of the solution.

Of course, this rural emergency medical service is but one of the facets in a giant problem presenting itself to the people of rural areas.

Michigan seems to be experiencing a population flow to the urban areas. Of course, physicians are part of this flow. This adds to the problem.

There can be little doubt that the difficulty rural areas are having in recruiting physicians makes the problem of rural emergency medical service more severe.

Lynne Holt, senior staff writer for the *Wichita* (Kansas) *Eagle and Beacon,* listed these major factors for this tendency of physicians to move to the cities, when he spoke to the 17th National Conference on Rural Health:

"1. Most physicians, particularly recent graduates, don't want to practice alone, because the responsibility is all on one man's shoulders — Vacations are few — time off is at a premium.

"2. A hospital in the community is a must with nearly all physicians.

"3. Physicians also insist on fully equipped laboratories, either in the office or in the hospital.

"4. The doctor frequently spends a year or more in general practice, then decides to specialize. This usually culminates in a move to a larger city.

"5. The physician's wife, even though she may come from a rural background, has enjoyed a new kind of life during schooling, internship, specialized training or military service. Except for 'died-in-the-wool' small-town girls, most have no desire to return to the quiet life."

While we do have this definite trend of movement out of the rural areas to the cities and suburban areas, so far as permanent housing and occupations are concerned, there is at the same time an increased mobility of these city dwellers, which makes it possible for them to flock back to the rural areas for vacations, recreation, visits, etc.

The rural highways are jammed with urbanites, "getting away from it all." The once-peaceful lakes and rivers where years ago farm boys fished with bent pins and swam dressed in nothing but goose bumps, are now being criss-crossed by high-speed power boats. The formerly tranquil snow-covered slopes of our rural hills are now being slalomed by city as well as urban skiers or snowmobiles. These people bring with them the emergency medical problems of broken legs, drownings, highway accident injuries, heart attacks and the other thousands of natural trials the flesh is heir to.

This makes the problem of rural emergency medical service something more than a purely rural problem. Rural accidents do not always happen to rural people.

THE RURAL AREAS are experiencing a change in the farming picture. Farms are being consolidated and are constantly growing larger. More land is being worked by fewer people because our engineering technology has provided the farmer with newer, bigger, faster machines. This technology also has provided the farmer, who already had a high-accident potential, with bigger, faster, more furious machines with which he could become entangled.

Add to these factors the decision of the funeral directors to no longer provide ambulance service in these rural areas Michigan faces, indeed, a need for action.

Doctor Rice, who is close to the situation, says we are pretty much in the talking stage so far as any direct action about the problem goes. It is gratifying to know that at least we are talking. There must be considerable talk and exploration before any action is taken.

While this problem of emergency medical service is but one of the many problems faced by the small rural community, it seems to be of prime interest and importance to these communities. The people of rural Michigan are giving this problem priority over some of the others.

CERTAINLY THE PROBLEM is known and is being faced by those who know it. The Ameri-

Continued on 635

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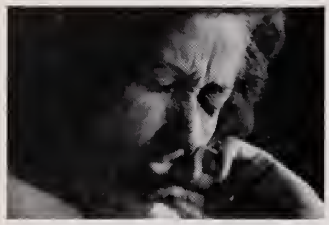
A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

Weariness "without cause"



Psychic tension with depressive symptomatology?

"For weeks I've done practically nothing and I'm always tired. I wake up tired and I go to bed tired. It's really absurd."

When the patient complains of fatigue, and you can find no organic cause, you recognize that it may serve her as a means of avoiding responsibilities or facing an emotional problem. It is, in effect, a psychological retreat behind a somatic cover of continuous fatigue —one of the many depressive symptoms often associated with psychic tension.

She needs counsel and reassurance, and perhaps a tranquilizer to attenuate excessive tension and help restore the capacity to cope. As an aid to successful management, consider the value of Valium® (diazepam). As psychic tension is eased by Valium therapy, secondary depressive symptoms too may subside. The patient feels more capable, therefore more hopeful; better able to handle situations of intense stress.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects —particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See **Precautions.**) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg, and 10 mg; bottles of 50, 100 and 500.

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Valium® (diazepam)

helps relieve psychic tension with associated depressive symptoms

VERMONTVILLE
F.D.

At a farm fire, the Vermontville rescue car (part of the fire department equipment) stands ready in case of a medical emergency.
(Photo by John Boughton)

can Medical Association's Council on Rural Health has offered a five-point program for improving emergency medical service in rural areas. This program, which was approved by the AMA Board of Trustees, urges that:

"1. Rural communities coordinate their efforts with adjacent towns in analyzing existing patterns of response to medical emergencies.

"2. Rural and urban communities institute a medical service area program for emergency medical transportation facilities and health personnel.

"3. Rural and urban cmmunities where possible, adopt the model ambulance ordinance to give the public a greater voice in the quality of ambulance care.

"4. Rural and urban communities provide a program of advanced Red Cross first aid instruction for the non-medical people most frequently called in rural emergencies — especially police, sheriffs and ambulance crews.

"5. Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and particularly young people through the schools, youth organizations and other educational channels."

According to the AMA Council on Rural Health, the long-term goal in first aid training is to have at least one member of every rural family trained in first aid procedures.

Jack R. Karel, M.D., in the Journal of the Medical Society of New Jersey, an expert in the field of disaster medical care, says that he senses a need for a change in our thinking toward this subject of emergency medical service. With the advent of the nuclear age, there seems to be a need for a new organization to cope with the tremendous number of casualties that might occur and to develop techniques and capabilities that could function under austere conditions.

He concludes that a good communications network, and a sound regionalization of control are the secrets of good disaster and emergency medical care.

Doctor Karel is of the opinion that every rescue squad and every ambulance should have a two-way radio to maintain contact with all hospitals in the area and also to maintain contact with law enforcement agencies. He says, "In time of great disaster, with excessive numbers of casualties, bedlam would otherwise ensue."

He also says that because of the importance of adequate training of ambulance attendants teaching should be standardized and intensified, and he believes this training of ambulance personnel should rest with each component medical society of the state.

MANY PHYSICIANS suggest that a community emergency medical care program can be available with an on-going daily program built around the emergency departments of all hospitals, good training of ambulance attendants in first aid, and most important, a well-coordinated and integrated communications network. All these efforts are underway in Michigan.

The most obvious answer to the problem of rural emergency medical service, of course, is prevention of rural emergencies. While this could never be accomplished 100 percent, an educational program, properly handled, should be able to greatly reduce the incidents of rural medical emergencies. Many farm and rural organizations are engaged in educational programs pointing up safety which, hopefully, will reduce the number of rural accidents.

Rural communities are making an effort to interest physicians in their areas. The Michigan State Medical Society and the Michigan Health Council, with the Health Careers Mobile, is helping to ease the situation by arousing interest in health careers.

Rural fire departments, sheriff departments and local police in many cases are stepping up their programs of first aid training, and governing bodies are trying to find ways to improve emergency procedures. Small hospitals are appraising their part in the picture. We may soon see the time when rural emergency medical service surpasses that of urban areas. □

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For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

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Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

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A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444

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control your
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Please see Brief Summary on next page.

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Brief Summary

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DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT
801444

Slides showing the incidence of arthritis in Michigan interest physicians who addressed a recent Licensed Practical Nurse Conference on Arthritis at Michigan State University. The authorities are, left to right, James J. Lightbody, M.D., medical director of the Michigan Chapter, Arthritis Foundation, and President-Elect, Michigan State Medical Society; Lanny Johnson, M.D., East Lansing orthopedic surgeon, and lecturer, Department of Anatomy, MSU College of Human Medicine, and Robert M. Daugherty, M.D., associate professor, Departments of Medicine and Physiology, MSU College of Human Medicine. The trio discussed aspects of diagnosis, treatment and nursing care of arthritis for more than 400 men and women LPN's at the Kellogg Center for Continuing Education. The Michigan Chapter of the Arthritis Foundation joined with the MSU School of Nursing and the Michigan Licensed Practical Nurses Association in sponsoring the educational event.

COMING AMA CONVENTIONS

1968:	San Francisco (June 16-20) Miami Beach (Dec 1-4)
1969:	New York City (July 13-17) Denver (Nov 30-Dec 3)
1970:	Chicago (June 21-25) Boston (Nov 29-Dec 2)
1971:	Atlantic City (June 20-24) New Orleans (Nov 28-Dec 1)
1972:	San Francisco (June 18-22) Atlanta (Nov 26-29)
1973:	New York City (July 15-19) Anaheim (Nov 25-28)
1974:	Chicago (June 16-20) Portland, Ore (Dec 1-4)

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Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.

Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.

Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.

In rare instances, transient cardia
arrhythmias have occurred in hyp
thyroid patients and in patients re
ceiving thyroid medication when
Tofrānil was added to the regimer
Imipramine may block the pharm
cologic activity of guanethidine a
other related adrenergic neuron-
blocking agents.

The drug is not recommended at
present time in patients under 12
of age.

Adverse Reactions: Dryness of th
mouth, tachycardia, constipation,
turbances of accommodation, sw
ing, dizziness, weight gain, urinai
frequency or retention, nausea ar
vomiting, peripheral neuritis, milc
parkinson-like syndrome, tremors
rare cases of falling in elderly pa-
tients, confusional states (with su
symptoms as hallucinations and
orientation), activation of psycho
schizophrenics and agitation (inc

When
a milestone in life
is marred
by depression...

Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by depression with such symptoms as feelings of sadness, incapacity, helplessness and hopelessness.

Tofrānil often relieves symptoms of depression.

As maintenance therapy during the active phase of depression, it may help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; or in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication, or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy, the special precautions listed in the prescribing information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the full prescribing information.

Tofrānil® imipramine hydrochloride
Geigy

manic and manic episodes)
ay require dosage reduction
ddition of a tranquilizer or
ry discontinuation of the drug,
orm seizures, orthostatic
sion and substantial blood
fall in hypertensive patients,
transient jaundice, bone mar-
ression including agranulocy-
nsitization and skin rash
g photosensitization, eosino-
nd mild withdrawal symptoms
en discontinuation after pro-
reatment with high doses.
nal hormonal effects (im-
, decreased libido, and estro-
fects) may be observed.
-like effects may be more
ced (e.g. paralytic ileus) in
ble patients and in those
ticholinergic agents (includ-
arkinsonism drugs).
nt Adult Dosage: Initially,
aily, increased, if necessary,

to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

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Division of Geigy Chemical Corporation
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TO-5522R

COMING EVENTS

HEART SESSIONS, MAY 10-11, FEATURE HOFFMAN LECTURE

An outstanding feature of the Michigan Heart Association Scientific Session May 10 and 11 in Detroit, according to Thomas James, M.D., chairman of the program committee, will be the Second Annual Wilson-Myers Lecture by Brian F. Hoffman, M.D., chairman of the department of Pharmacology, at the College of Physicians and Surgeons at Columbia University.

Doctor Hoffman's topic will be "Electrophysiology of the Heart."

The Wilson-Myers Lecture was inaugurated to commemorate the internationally-famous work of Frank Wilson, M.D., and Gordon Myer, M.D., in the field of electrocardiography and electrophysiology.

To be held at the Rackham Building in Detroit, the program will identify various arrhythmias, their physiological implications and management. The session will offer seven credit hours by the American Academy of General Practice.

Friday morning, May 10, will be devoted to an EKG seminar for technicians, followed by the annual luncheon meeting of members.

At the end of each afternoon session, there will be time for informal discussion with speakers.

A complete program is available from the Michigan Heart Association, 13100 Puritan, Detroit 48227. □

Visschers to Lead RH Immunoglobulin Session, May 20-21

At the forthcoming meeting of the MSMS Committee on Maternal Health at the Kellogg Biological Station, Gull Lake, May 20 & 21, Robert Visscher, M.D., and Harrison Visscher, M.D., of Grand Rapids will report on the possibility of the Michigan Department of Public Health making Rh Immunoglobulin for general use throughout the state and setting up areas where plasma can be obtained. □

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Pectin .... (2½ grains) 162 mg.
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HYDROXYZINE PAMOATE

an antianxiety agent that serves a human need...

"The danger involved in prescribing dependency producing medication for relief of anxiety lies in the fact that we do not know in advance the dependency proneness of the individual."[1]

A woman who is undergoing the emotional stresses of the menopause may, for the first time, need an antianxiety agent. But she may also be susceptible to drug abuse.

Vistaril can fulfill the need for tranquilization without creating a new need—dependency.

Vistaril calms anxiety and agitation quickly—usually begins to work in 15-30 minutes. And, in more than ten years of clinical use, after more than a billion doses to date, there have been no reported instances of dependency on hydroxyzine.

When the need for antianxiety medication is reduced or no longer exists, Vistaril dosage may be lowered or discontinued without ill effects.

Recommended starting dose, anxious menopausal patient, 50 mg. t.i.d.

With Vistaril, it is as easy to stop therapy as it is to start.

ithout
eating
new one.

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

The intravenous administration of this drug is not recommended for children under 12 years of age.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.–10 cc. vial and 50 mg./cc.–2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

References: 1. Greenhouse, H. R.: Medication and the Dependent Personality, Symposium of Non-Narcotic Drug Dependency and Addiction, The Amer. Psychiat. Assn., N.Y. County Dist. Branch, New York, N.Y., March 10, 1966.

Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

burning
itching
discharge
of trichomonal vaginitis...

Flagyl® tablets/inserts

rand of

netronidazole

rings
clinical cures
microscopic cures
culture cures

or the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physians have reported a cure-rate of 95 er cent or more with Flagyl when incted male partners are treated conurrently and when treatment is peated for occasional refractory inctions in women.

Among the few patients who do not spond to Flagyl are those who may ot have taken the prescribed dosage nd those who may have been reinected.

This high rate of cure obtained with lagyl is unparalleled. Only systemially active Flagyl reaches the hidden servoirs of reinfection in male and male genitourinary tracts.

lications: Flagyl is indicated only in the atment of trichomoniasis in both the male d female.

ntraindications: Pregnancy; disease of the ntral nervous system; evidence or history of od dyscrasia.

caution: Complete blood cell counts should made before, during and after therapy, esially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

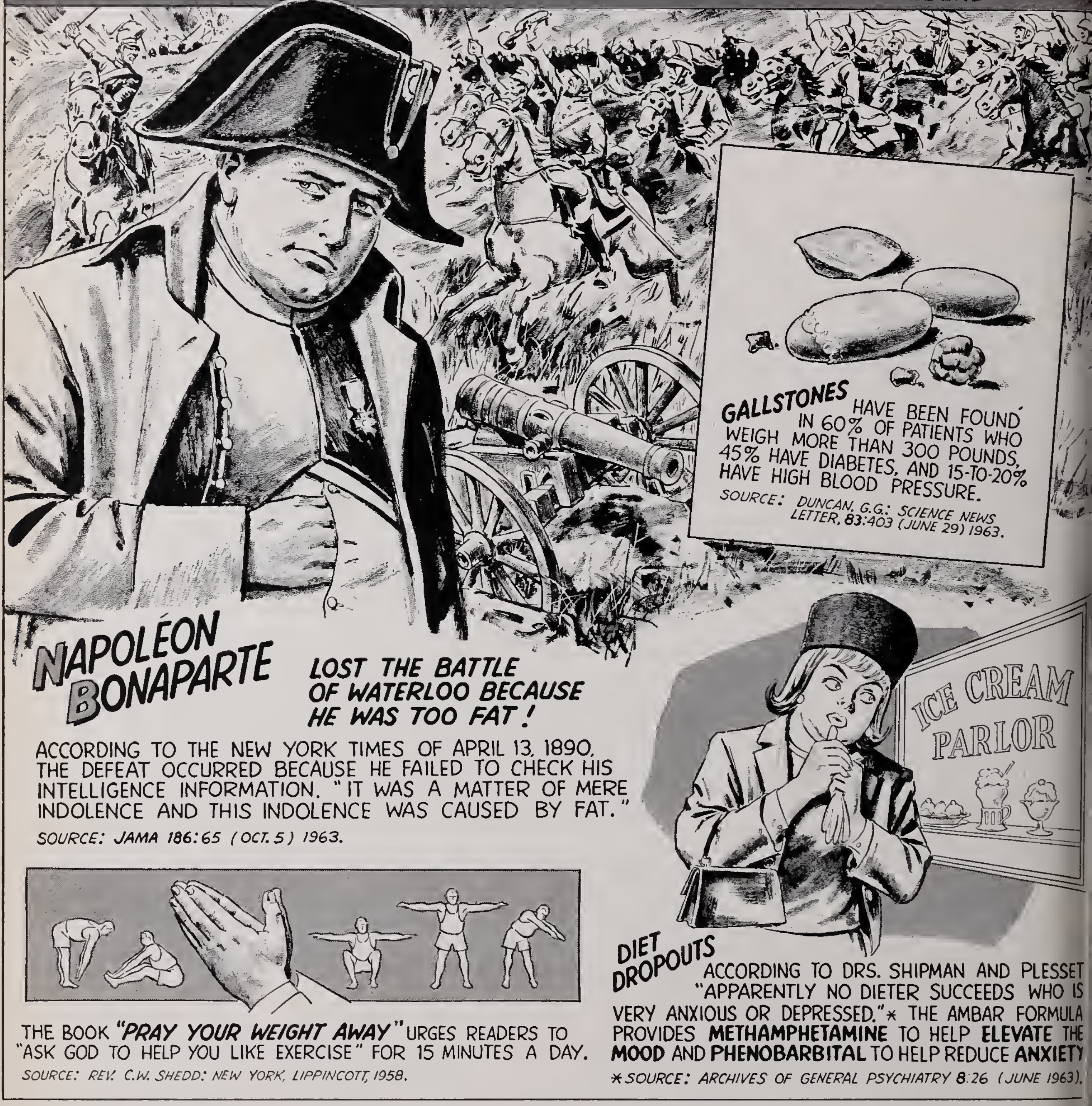
Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE *LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!*

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.

THE BOOK ***"PRAY YOUR WEIGHT AWAY"*** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY**

**SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).*

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DO

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

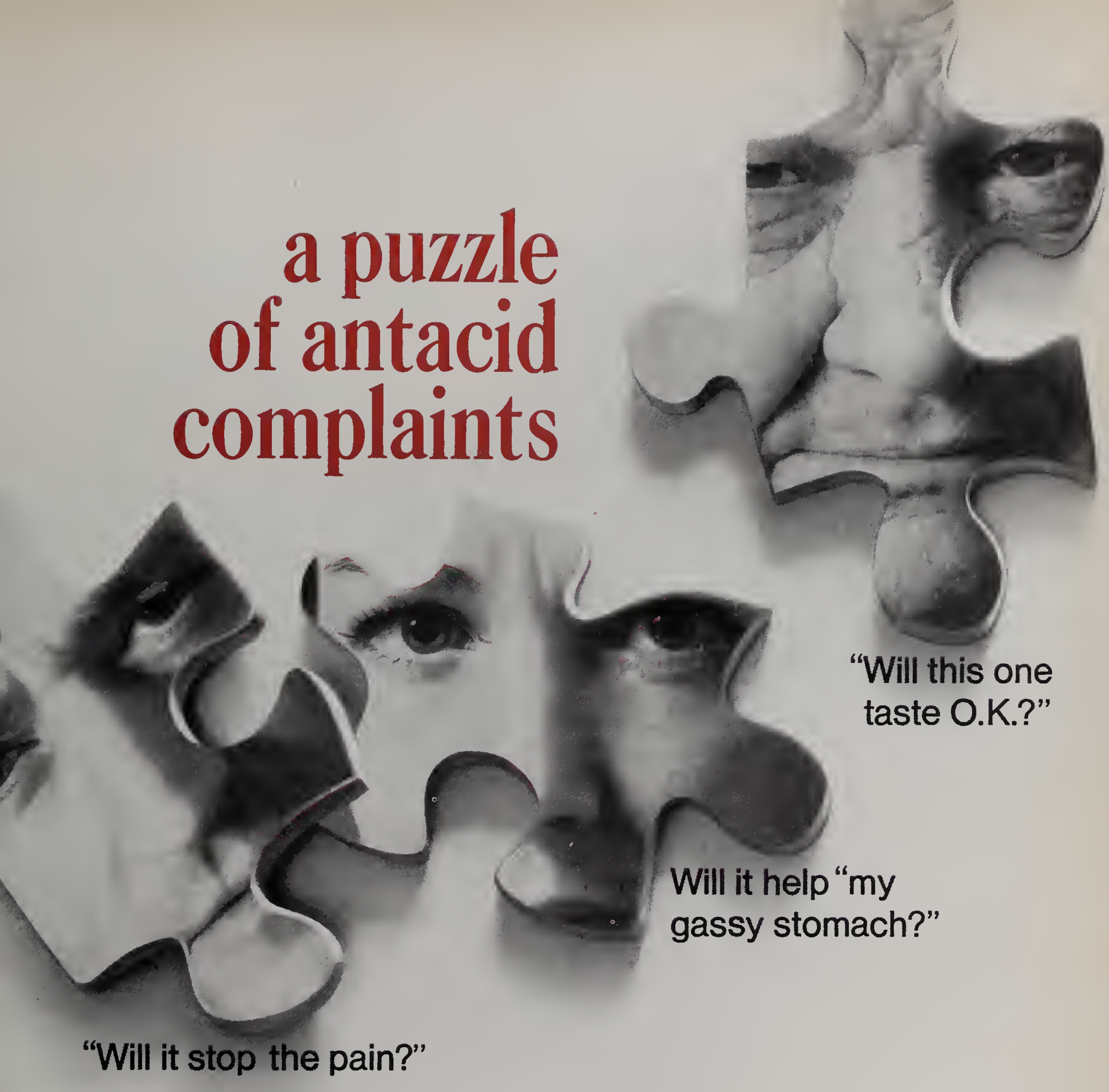
Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Am suppresses appetite and helps offset e tional reactions to dieting. **Contraindi tions:** Hypersensitivity to barbiturates sympathomimetics; patients with advan renal or hepatic disease. **Precautions:** Administer with c tion in the presence of cardiovascular disease or hypertensi **Side Effects:** Nervousness or excitement occasionally not but usually infrequent at recommended dosages. Slight dro iness has been reported rarely. See package insert for furt details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBI

a puzzle
of antacid
complaints


"Will this one
taste O.K.?"
Will it help "my
gassy stomach?"
"Will it stop the pain?"

Mylanta®
aluminum and magnesium hydroxide *plus* simethicone

a solution
to peptic ulcer
distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I.E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

When the agitated geriatric disrupts the home...

His daughter can't please him. There is "just no living with him."

His disturbances at the table make every meal a nightmare.

His teen-age granddaughter won't invite friends home because of his outbursts.

His slovenly room and habits create more tension.

In moderate to severe anxiety...

- Mellaril helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- Mellaril often alleviates anxiety-induced somatic complaints
- Mellaril frequently helps strengthen emotional resources
- Mellaril helps the patient maintain realistic contact with environment, closer harmony with family

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atr pine, and phosphorus insecticides. Where complete mental ale ness is required, administer the drug cautiously and increa dosage gradually. In addition, orthostatic hypotension (especi ly in female patients) has been observe Epinephrine should be avoided in tre ment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism a other extrapyramidal disorders are i frequent; drowsiness, especially in hi doses early in treatment, may occ nocturnal confusion, dryness of t mouth, nasal stuffiness, headache, p ripheral edema, lactation, galactorrhe and inhibition of ejaculation are not on occasion; photosensitivity and oth allergic skin reactions may occur but a extremely rare.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ

Before prescribing, see package insert for full product information.

In Obesity,
anorectic action
with fewer unwanted
side effects

CYDRIL®
(levamfetamine succinate TUTAG)

Cydril at 2 p.m.
Appetite control at 6
Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

S. J. TUTAG & CO.
ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234

MEDISCENE

April 30-May 1 — Woman's Auxiliary Spring Conference, MSMS Headquarters and Kellogg Center, MSU, East Lansing

May 1 — Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8 — Mental Health Week

May 4 — Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 6-8 — Michigan United Fund, Kellogg Center, East Lansing

May 8-10 — Michigan Public Health Association, Annual Conference, Jack Tar Hotel, Lansing

May 10-11 — Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 17 — Kresge Eye Institute Clinic Day, Detroit

May 17-18 — Junior Academy of Science, Kellogg Center, East Lansing

May 18-19 — Pediatric Clinic Days

May 22 — Annual Muscle Symposium, Wayne County Medical Society, Detroit

June 5 — The Council, MSMS Headquarters, East Lansing

June 16-20 — 1968 AMA Annual Convention, San Francisco

June 21-22 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

July 20-21 — MSMAS Summer Seminar, Boyne Highlands, Harbor Springs

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

ACTIVITIES, PROJECTS

Four Doctors Serve On Board for New Data Clearinghouse

Four physicians are serving on the board for the recently-formed Michigan Health Facilities Data Clearinghouse.

MSMS spokesmen are hopeful that MHFDC will work closely with the Michigan Health Information Research Institute, being developed under MSMS guidance.

MHFDC will inventory and analyze the data generated in short-term impatient hospital facilities and the demand for this data by interested health agencies and individuals. The project is based at the Commission on Professional and Hospital Activities in Ann Arbor.

The doctors on the board include MSMS Past President Otto K. Engelke, M.D., Vergil N. Slee, M.D., and Lawrence Birch, M.D., all of Ann Arbor; and J. K. Altland, M.D., Lansing.

Funds for the Clearinghouse project are being provided by the Michigan Department of Public Health under a contract to the Commission on Professional and Hospital Activities. □

WIVES CONFER WITH LEGISLATORS
Speaking with Representative William P. Hampton, Bloomfield Hills, during the recent Woman's Auxiliary Legislative Day in Lansing, are (left to right) Mrs. Dale R. Drew and Mrs. John R. Lichtwardt, both of Bloomfield Hills.

Members of the MSMS Governmental Affairs Committee, at its last meeting, conferred with two Michigan medical leaders. Invited as guests were Albert E. Heustis, M.D., left, executive director of the Michigan Association for Regional Medical Programs; R. G. Rice, M.D., middle, acting director of the Michigan Department of Public Health. Listening intently to their comments is Paul T. Lahti, M.D., right, Royal Oak, chairman of the MSMS Committee.

Krevsky Serving In AMA Viet Plan

Seymour Krevsky, M.D., Detroit, is in South Viet Nam for two months, serving the civilian population with the American Medical Association Volunteer Physicians for Viet Nam.

He is a pediatrician in private practice and director of nurseries, Detroit Memorial Hospital. Practicing in Philadelphia 1960-64, he was instructor of pediatrics at the University of Pennsylvania Graduate Hospital and was affiliated with Presbyterian Hospital.

Doctor Krevsky attended Lehigh University, Bethlehem, Pa., and Yeshiva University, New York City, and received his medical degree from Jefferson Medical College, Philadelphia, Pa.

AMA Volunteer Physicians for Viet Nam is administered by the American Medical Association, under contract, for the United States Agency for International Development. It is a program designed to use the volunteer services of U.S. physicians to assist in meeting the health needs of the Vietnamese civilian population. □

**WHEN YOU MOVE — LET US KNOW!
WE WANT YOU TO BE SURE TO GET
THE NEXT ISSUE OF THE
MICHIGAN MEDICINE**

Feldkamp Installed; Haddock, Danforth Elected by G.P.s

Lee Feldkamp, M.D., right, receives congratulations as the new president of the Michigan Academy of General Practice from J. L. Leach, M.D., who completed his year. At left is Douglas A. Haddock, Jr., M.D., who will serve as president during 1968-69.

Lee Feldkamp, M.D., Plymouth, was installed as president, and Douglas A. Haddock, Jr., M.D., Kalamazoo, selected as president-elect at the recent 22nd annual convention of the Michigan Academy of General Practice.

The installation was impressive with J. L. Leach, M.D., Flint, as the outgoing president. Special guests at the annual banquet at the Sheraton-Cadillac Hotel Grand Ballroom included Frank Bicknell, M.D., President, W.C.M.S., and James J. Lightbody, M.D., President-Elect of MSMS; Assistant Dean Morton Levitt, Ph.D., of Wayne State University; Dean Andrew Hunt, Jr., M.D., Michigan State University School of Human Medicine and Mrs. William N. Hubbard, Jr., M.D., representing her husband, Dean Hubbard, University of Michigan Medical School, who was out of the state on pressing University affairs.

Other officers elected were Secretary, E. C. Long, M.D., Detroit; Treasurer, Robert Oakes, M.D., Harbor Beach; Directors, H. R. Allott, M.D., Sault Ste. Marie; W. D. Peterson, M.D., Traverse City; T. J. Rupp, M.D., Grand Rapids; H. Weisheit, M.D., Sturgis; H. A. Habenicht, M.D., Jackson; Lewis Simoni, M.D., Flint; T. F. Lange, M.D., Lansing; C. Ludwig, M.D., Port Huron; R. Vitu, M.D., Saginaw; Joseph Schirle, M.D., Pontiac; Leon Rottenberg, M.D., Detroit; and L. R. Zako, M.D., Allen Park.

The delegates elected James J. Danforth, M.D., Detroit, as Speaker and James F. Dooley, M.D., Flint, Vice-Speaker. Chosen as delegate to the A.A.G.P. was Clark W. Royer, M.D., Battle Creek; Alternate Delegate, J. L. Leach, M.D., Flint.

The convention program and banquet menu were printed in green and gold to commemorate the WSU School of Medicine Centennial.

"The clinic, in spite of a state-wide storm that rendered driving expressway hazardous and hampered operations at Metropolitan Airport, our twenty-four guest speakers from all sections of the United States, arrived and delivered their papers on schedule. Although the storm reduced our usual outstate representation, this was offset by more physicians than ever attending from the greater Detroit area," reported F. P. Rhoades, M.D., Detroit, director, M.A.G.P. Scientific Assembly.

Doctor Rhoades reported that "in addition to the formal program, there were 32 scientific exhibits present selected to complement each of the papers presented as well as amplifying the five wet clinics. All wet clinics were well attended with over 115 of our members present, and the five clinics were provided with appropriate patients suffering from the disease or disorder being covered. Local voluntary health agencies cooperated in supplying the patients. These included the Arthritis and Rheumatism Foundation, the Michigan Allergy Society, and the Kresge Eye Institute: others supporting the program were Michigan Epilepsy Center, and the Michigan Heart Association." □

COLE HONORED

Wyman C. C. Cole, Jr., M.D., of Detroit, past chairman of the Board of Directors of MDPAC, receives a plaque commemorating his outstanding work with the organization from Vernon V. Bass, M.D., of Saginaw, present chairman of the Board, at a recent MDPAC meeting in Detroit.

Participating in a recent MAP Formula TV program were, left to right, host, Hugh Brenneman, MSMS Executive Director; George W. Slagle, M.D., Battle Creek; Edward R. Annis, M.D., Miami, and Frederick C. Swartz, M.D., Lansing. "Formula for New Medical Care" was the topic. Doctor Slagle is Chairman of the AMA Council on Medical Service, and a Past President of MSMS. Doctor Annis, a graduate from the University of Detroit, is a Past President of the AMA and the World Medical Association. Doctor Swartz, who helped originate the Rehabilitation Center at Sparrow Hospital in Lansing, has served several years as Chairman of the AMA Committee on Aging.

VIET MEDAL OF HONOR AWARDED TO SWANSON

For his assistance to the South Vietnamese medical community, Alfred B. Swanson, M.D., of Grand Rapids, has been awarded the South Vietnamese Medal of Honor. Since 1962, Doctor Swanson has made four volunteer trips to Southeast Asia.

The citation noted that he "has successfully operated on military patients treated in Cong Hoa Military Hospital and provided theoretical and practical training to Vietnamese surgeons, with fully satisfactory results."

Doctor Swanson is chief of the orthopedic department at Blodgett Memorial Hospital and chief of staff at Mary Free Bed Hospital. ☐

HELP NEW PARENTS IN OAKLAND COUNTY

The Oakland County Medical Society will cooperate with the Oakland County Health Department and various adult education departments to offer a series of eight classes for expectant parents.

The classes, which are taught by public health nurses, make use of films and other audio-visual aids and include a hospital tour. ☐

YOU AREN'T A BANKER DOCTOR . . .

Too much of your time is taken up with "banking matters" — primarily the follow-up on patient's unpaid bills for your services. If your patient belonged to the American Health Credit Plan, he could arrange for A.H.C.P. to pay his bills — with something we call "instant money." You get paid instantly, eliminating unnecessary office work. Through the A.H.C.P. plan you have more time — time to be a doctor, instead of a banker.

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MICHIGAN'S ONLY
MEDICAL CREDIT CARD

State Medical Auxiliary Promotes Home-Centered Health Care Program

BY MRS. E. C. GALSTERER, CHAIRMAN
STATE WOMAN'S AUXILIARY
HOME-CENTERED CARE

The Woman's Auxiliary to the Michigan State Medical Society has joined this year in a nationally-supported, medically-oriented community service program, dedicated to providing home health care in special cases in order to relieve pressure on regular medical and hospital facilities.

Especially encouraged are: (1) Homemaker Service, (2) Portable Meals, and (3) Voluntary Friendly Visitors.

While the first of these is the most comprehensive program, there are many cases in which a more simple service, such as regular personal contacts or assurance of balanced meals, would be adequate. All three programs should be of interest to the medical profession and are appropriate fields of interest for doctors' wives. The wives can through these projects provide emergency assistance, adequate nutrition and stimulation of interests to the chronically ill, disabled, handicapped, the lonely and homebound elderly, and those who need temporary care due to special problems in the home. They make home care possible for many patients who might otherwise require space in hospitals or rest homes.

However, these services should be considered not as a substitute for hospital or institutional care but as part of a total medical care plan.

HOMEMAKER SERVICE, for example, can serve not only to provide home help for a patient who could go home from the hospital sooner, if being at home did not involve too many household duties, but also can help the home and family to function normally when the mother is suddenly hospitalized, so that the wage earner need not stay at home or the children be boarded out. Clients usually pay for this service insofar as they are able. Moreover, there is customarily a time limit involved in such service which is intended to take care of the emergency without providing long-term, high-priced maid service at the expense of civic-minded women.

Auxiliaries have been encouraged to act as catalysts in promoting community interest in such projects, providing necessary training courses for special services, and recruiting volunteers. Some have offered the services of their own members. Most projects, however, are carried out in cooperation with an existing social service agency. Several Michigan County Auxiliaries have shown interest in this program and are investigating the extent of need and possibility of continued support in their communities.

ONE GROUP WHICH recently inaugurated such a service is the Bay-Arenac-Iosco Counties Auxiliary, whose "Mobile Meals" program began operation on April 1st, after a full year of study and inquiry under the leadership of Mrs. Nicholas Csonka. The present coordinator is Mrs. Kent Alcorn.

With the participation of Bay City's Mercy Hospital in planning, preparing and packaging the meals, the cooperation of the Nursing Bureau in providing telephone answering service, the service of the Visiting Nurses and Public Health Department in screening applicants, and the guidance of the Child and Family Service in instructing drivers, the Auxiliary volunteers are putting into effect a three-month pilot project for up to ten clients. Five days a week, they provide a hot noon meal, a cold supper, and supplies for the next day's breakfast, at a price of $2.00 a day—a charge barely above cost.

Financial backing to start this project comes from a share of the proceeds of the Auxiliary's annual Christmas card sale. At present, all clients pay for their own meals. Auxiliary leaders, however, anticipate expansion of this demonstration project into a community program and hope for sufficient funds to make possible lower meal prices adapted to the economic status of those who are most in need of such service. ☐

Hairy sites where creams and ointments do not spread or penetrate readily.
Exposed areas where cosmetic considerations are important.

An invisible topical

for many dermatologic problems

Moist or intertriginous-areas where drying action is desirable.

See last page for contraindications, precautions and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication — or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

Ideal for moist or intertriginous areas.

Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.

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d topical corticosteroid.

and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

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MSMS Presents New 'Flag Awards'

Photos from 1968 Awards Luncheon At Conference on Health Planning

Carl B. Beeman, M.D., right, of Grand Rapids, received a Michigan State Medical Society Flag Award. Unable to attend the recent Michigan Health Planning Conference in Detroit, Doctor Beeman received his award in Grand Rapids. He was cited for "his distinguished leadership as president of the Michigan Heart Association. C. Allen Payne, M.D., Grand Rapids, past president of the medical society, presents the award.

John J. Hanlon, M.D., right, of Detroit, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of Michigan Public Health Association. B. M. Harris, M.D., society president, presents the award.

George D. Maniaci, M.D., right, of Gladstone, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Association for Retarded Children." The award was presented by MSMS President B. M. Harris, M.D.

HEALTH
PLANNING
CONF CE

Donald R. Hagge, M.D., left, of Livonia, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Archaeology Society." B. M. Harris, M.D., Ypsilanti, society president, presents the award.

HIGAN
ALTH
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CE

William N. Hubbard, M.D., right, of Ann Arbor, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Association for Regional Medical Programs." MSMS President B. M. Harris, M.D., offers congratulations.

HEALTH
PLANNING
CONFERE

G. Frederick Moench, M.D., left, Midland, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Society for Better Hearing and Speech." The citation was presented by MSMS President B. M. Harris, M.D.

Photos of More Distinguished Leaders

John B. Rowe, M.D., right, Flint, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Diabetes Association." The award was presented by MSMS President B. M. Harris, M.D.

PLANNING
CONFERE

Harry A. Towsley, M.D., left, of Ann Arbor, received a Michigan State Medical Society Flag Award from B. M. Harris, M.D., Michigan State Medical Society president, at the recent Michigan Health Planning Conference in Detroit. Doctor Towsley was cited for "his distinguished leadership as president of the Michigan Health Council, and also the Michigan United Fund."

G. B. Saltonstall, M.D., of Charlevoix, was cited for "his distinguished leadership as president of the Michigan Association of the Professions."

SALTONSTALL

JEFFRIES

Benjamin Jeffries, M.D., of Detroit, was cited for "his distinguished leadership as president of the Michigan Epilepsy Center and Association." Doctor Saltonstall and Doctor Jeffries were unable to attend the Conference to receive their awards.

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What Is Current Thrust of MSMS In Civic and Community Affairs?

Civic and community affairs have always been — and certainly are today — a concern of MSMS. Where does MSMS stand regarding civic and community affairs? That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Thirteen different questions are discussed in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS. The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed any of the previous articles may wish to go back and read them. The following article is Chapter VIII in the booklet.

CIVIC AND COMMUNITY AFFAIRS

Discussion

Relationship Between Patient Environment and Physician Concern

The relationship between some non-medical issues and the practice of medicine has never been clarified in MSMS literature, but a very real connection exists. Involvement in issues with which the public has a vital stake enables a physician to become more aware of the requirements of society.

For example, how many physicians visit neighboring industrial plans, tour neighborhoods to see living conditions, acquaint themselves with sanitation problems — or even familiarize themselves with what agencies provide what services in the communities in which their patients live?

How can the physician demonstrate a personal concern for his patient, assist him in avoiding illness and accident, if he has no familiarity with the working and living conditions of the patient and his family? Has this lack, coupled with improved transportation (causing a decline in house calls), an answering service, and a central medical office building caused the physician to become isolated from the problems of his patient and given him the image of an efficient impersonal individual?

Human Resources Council

Physicians can get involved in a myriad of organizations, offer guidance through them towards improving the health of the public, and thus the profession can identify itself with the problems of individuals. One of the ways this can be done is through participation in the work of the Human Resources Council, which sponsored the Michigan Assembly,* a meeting called in cooperation with the University of Michigan to study the future of the environment and employment of the people of Michigan.

Highway Accident Prevention
Air-Water-Land Pollution
Population Control

Others open for participation are these organizations involved in highway accident prevention; air, water, and land pollution; conservation clubs, PTA, chambers of commerce, conferences on population control,* etc. These tend to be one step removed from the sociological medicine where health is the pervasive subject.

---

*MSMS participated

Contact Via MAP and TV with Other Professions

MSMS has been particularly effective in these fields, in part because of its participation in MAP and the "Formula" television program, which has supplied a broad base for contact with community affairs.

Political Candidate Support

Particular attention is deserved by MDPAC, which has not received the support in Michigan that similar organizations have in other states. In many states PAC dues have been collected concurrently with state society dues. There is need for continued study of this. But regardless of financing, the work of this organization, which has been well begun, needs greater MD interest if it is to continue to be effective in the support of political candidates who reflect this profession's policies.

Urbanization Civil Rights

Two other areas where physicians might make contributions to civic and community affairs are the advices they can give in urbanization and civil rights.

Community Health Week

Community Health Week, of course, offers amazing opportunity for involvement in community activity. However, this activity tends to fall in the communications and public relations or socio-medical fields of interest rather than in the "other-than-health" thrust of this section.

The above is not said to deprecate or ignore the fine work of many physicians in serving in local school boards, city councils, village and township boards, etc. Quite the contrary, this type of service is of the essence.

Questions

A. Should a study be made of the role MSMS should play in resolving the Negro problem? **Negro Problem**

B. Should a study be made of the probable effect the civil rights movement will have upon medical practice in Michigan? **Civil Rights**

C. Should the MSMS finance any part of MDPAC activity? **MDPAC**

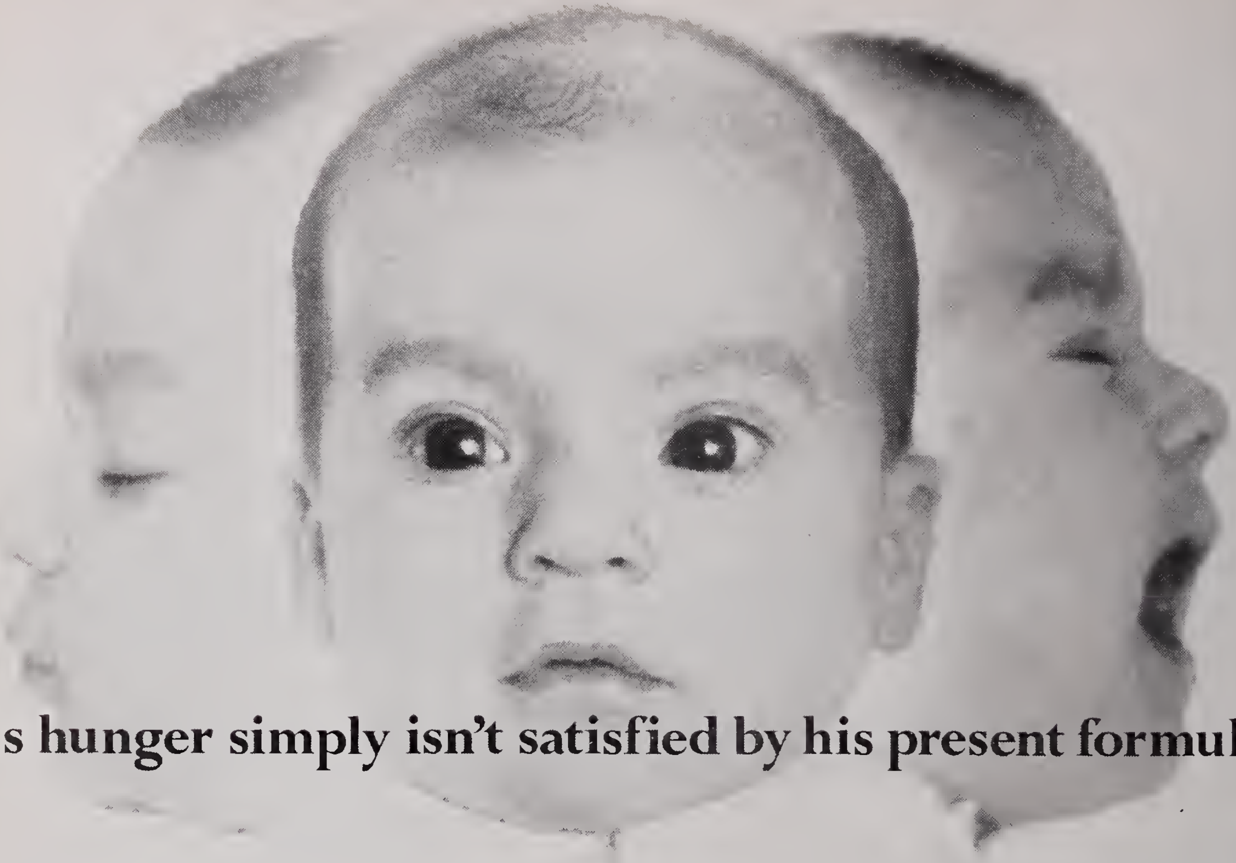
D. Should the MSMS participate in Human Resources activity **Human Resources**
   1. As a leader?
   2. As an active participant?
   3. Not participate?

E. What part should MSMS play in population control? **Population Control**
   1. Assist it?
   2. Ignore it?
   3. Oppose it?

F. Should the MSMS participate actively in the national, state, and local chambers of commerce? **Chamber of Commerce**

G. Should the MSMS establish any formal liaison with the Michigan Congress of Parents and Teachers or the Michigan Association of Child Study Clubs, and other parent education groups? **PTA, etc.**

H. Should MSMS be an active participant in anti air, water and land pollution campaigns? **Air-Water-Land Pollution**



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Caprylic	3.3	1.6	2.2
Capric	2.2	1.1	1.5
Lauric	16.0	10.1	11.7
Myristic	6.3	5.1	5.5
Palmitic	10.2	16.2	14.0
Stearic	2.3	9.0	4.5
Unsaturated	**59.6**	**55.8**	**61.0**
Oleic	40.7	33.0	24.7
Linoleic	18.9	19.5	34.6
Linolenic	trace	2.3	1.7

* Mean of three lots tested

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1. Hansen, A. E., et al: Pediatrics 31:171, 1963. 2. Holman, R. T.: Fed Proc. 23:1062, 1964. 3. Holman, R. T., et al.: Amer. J. Clin. Nutrition 14:70, 1964. 4. Hepner, R., et al.: Pediatrics 33:94, 1964. 5. Pikaar, N.A., and Fernandes, J.: Amer. J. Clin. Nutrition 19:194, 1966. 6. Hepner, R.: Current Therapeut. Research 9:140 (Suppl. 35) 1967. 7. Hart, L. M.: Ibid., p. 179. 8. Nichols, M. M.: Ibid., p. 184. 9. Young, R. J. and Garrett, R. L.: J. Nutrition 81:321, 1963.

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E. Stewart Taylor, M.D., right, chairman of the department of Obstetrics-Gynecology at the University of Colorado Medical Center, was one of the featured speakers at the MSMS Maternal Welfare Conference in Flint recently. His daughter, who lives in Ann Arbor, and William W. Jack, M.D., left, of Grand Rapids, immediate past chairman of the Maternal Welfare Committee, confer with Doctor Taylor.

Rh Immunoglobulin, Abortion Discussed At Flint Conclave

BY PETER HOHEISEL
OF THE MSMS STAFF

Early in the program, the challenge faced by the 1968 Maternal and Perinatal Welfare Conference held in Flint recently was outlined by William W. Jack, M.D., immediate past chairman of the conference.

"Here in Michigan we need to improve our perinatal mortality rate," Doctor Jack said. "In cooperation with the Maternal Health Committee, the State Health Department has released statistics recently showing that while the national mortality rate per thousand live births is 23.4, Michigan statistics have ranged, in the period 1964-66, from 27.4 to 32.7 depending on the size of the hospital participating in the study."

Topics dealing with this subject at the conference ranged from "Neonatal Environmental Control" to "Infertility." One-hundred-seventy-five physicians, 22 osteopaths, and 146 others from medical and social work groups, making a total of 343, participated in the conference.

Many participants voiced appreciation for the work of the 1968 Maternal and Perinatal Welfare Conference Committee, chaired by Jack W. Thompson, M.D., of Flint, for preparing an educational program on a wide spectrum of subjects of interest to physicians, medical personnel, and the public.

A TALK WHICH attracted national as well as local news attention was "New Abortion Laws," by E. Stewart Taylor, M.D., chairman of the department of obstetrics-gynecology at the University of Colorado Medical Center.

Doctor Taylor gave a report on how the new abortion law in Colorado has been working during a nine month period, May 1, 1967, to February 1, 1968. Out of a possible 52 hospitals, accredited by the Joint Commission, 23 have established boards to handle theraupetic abortions in Colorado, he said.

In the nine month period, 224 abortions, a ninefold increase over previous years, have been performed. 145 of these women were Colorado residents; the rest were out of state, Doctor Taylor said.

Single women had 51% of the abortions; married women, 36%; divorced, 10%; and widowed, 3%.

PSYCHIATRIC REASONS LED the list of indications for abortion with 67%. Most of the psychiatric conditions, Doctor Taylor said, were related to "reactive and situational depression." Some hospital boards require that the condition be present before the pregnancy. Fetal problems, rape, and medical difficulties for the women, in that order, accounted for the rest. Maternal rubella was the main culprit in fetal indications. Forty of the 224 abortions resulted in further complications. This high incidence, according to Doctor Taylor, was based on the "red tape" involved in getting the abortion approved.

With regard to the socio-economic status of the women receiving the abortions, over 50% of them were in a family income bracket of less than $5500 a year. "This shows," said the Colorado physician, "that therapeutic abortion isn't available only to those who can afford it."

Doctor Taylor remarked that the new abortion law was working out well and that, contrary to what some of the critics had predicted, Colorado was not becoming the "abortion mecca of the country."

He preferred to describe the law as "permis-

Continued on 671

vol. 3, no. 2

DORSEY Season

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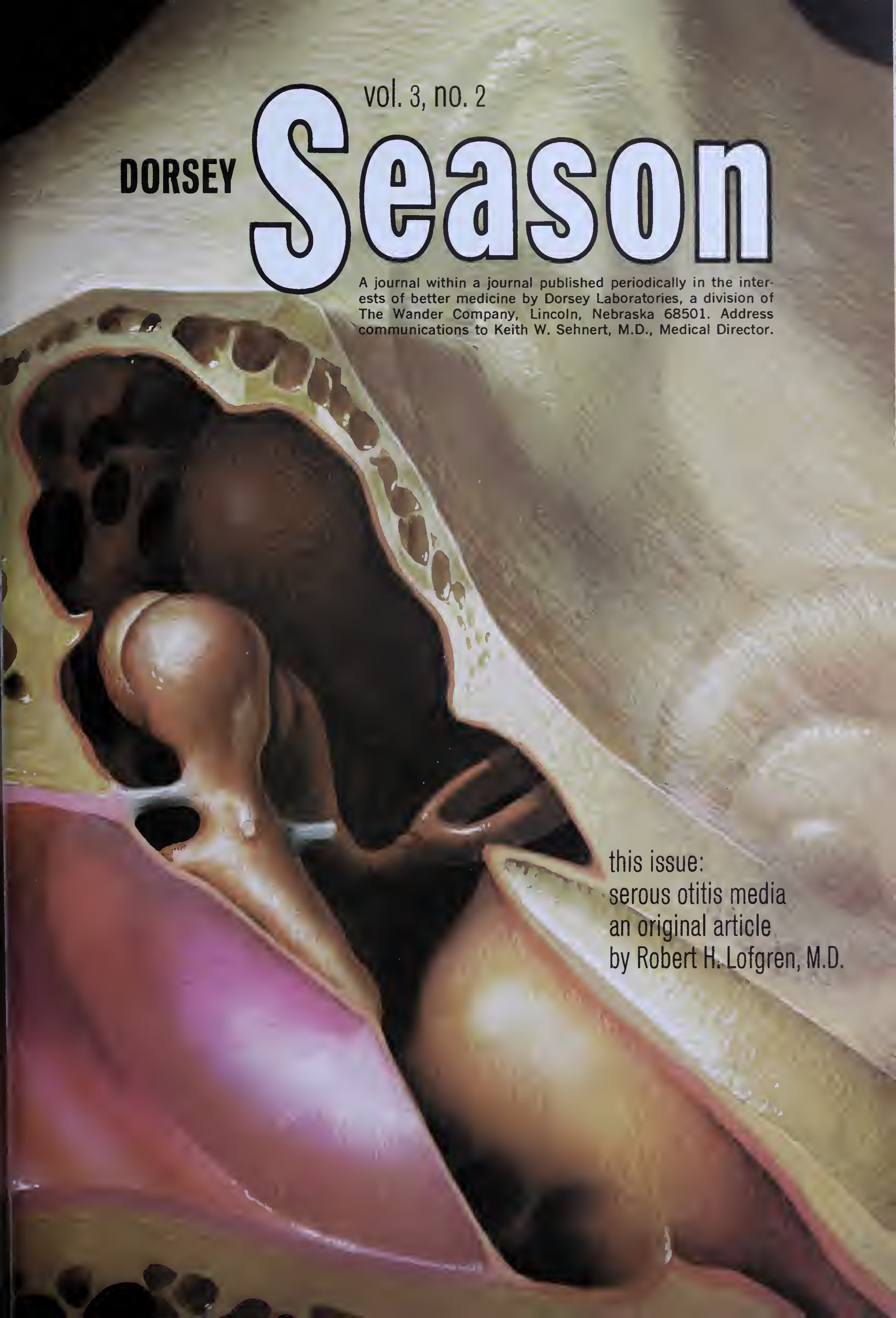
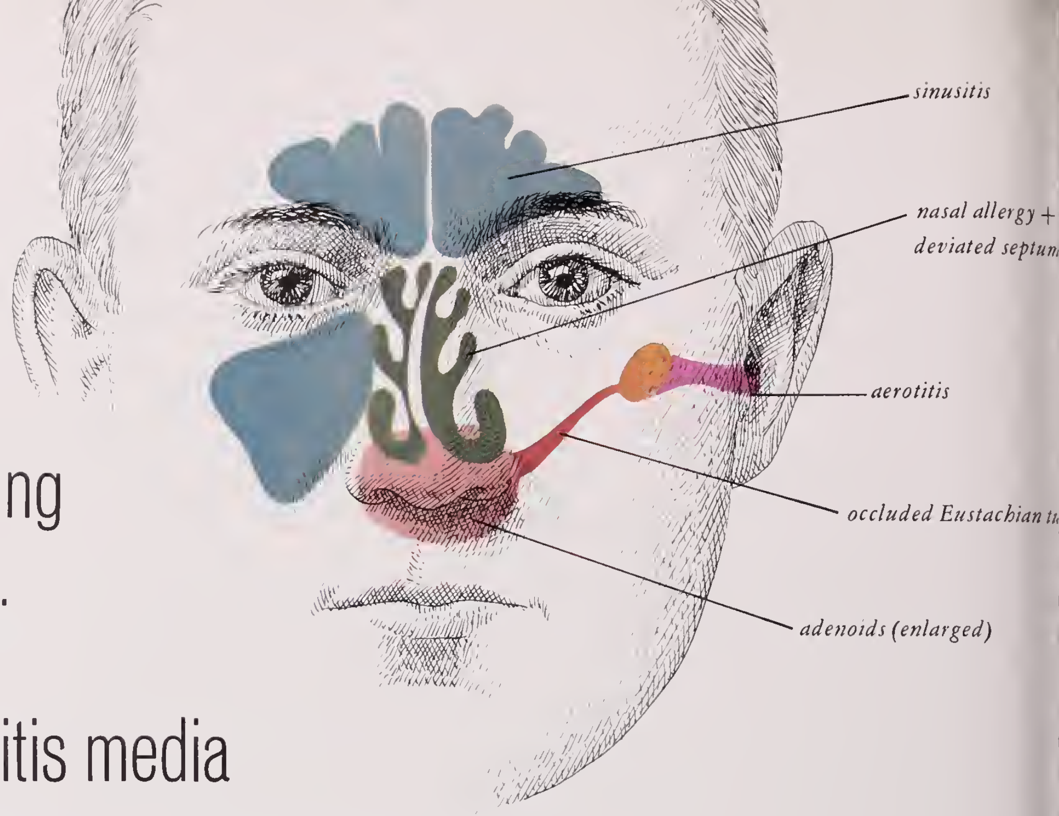


this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

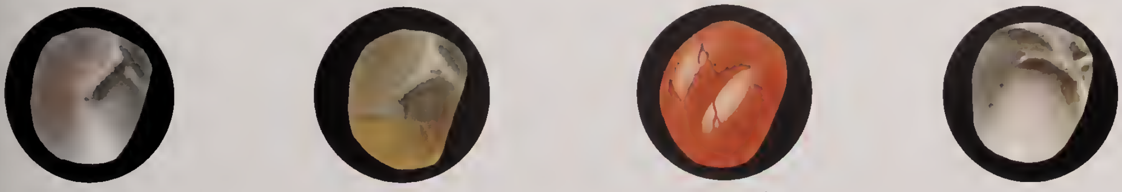
If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal *Acute Serous* *Acute Purulent* *Chronic Serous* dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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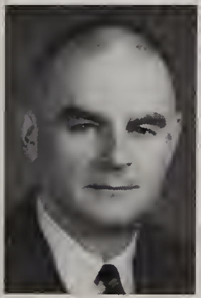
sive" rather than "liberalized." It leaves the choice of seeking a termination to pregnancy entirely up to the patient and does not force any doctor, nurse, or hospital to participate. "How much, how often, and who" shall have an abortion is entirely up to the conscience, judgment and medical ethics of a given hospital staff, Doctor Taylor said.

Compared to countries which have an extremely permissive abortion law, such as Japan or Sweden, the ratio of abortions to live births is very low, Doctor Taylor concluded.

DISCUSSING THE OTHER side of the coin — how to get pregnant and stay that way — was Herbert Horne, Jr., M.D., from the department of obstetrics-gynecology at Harvard Medical School. Speaking on "Infertility," Doctor Horne outlined the complicated process by which the male sperm reaches the ovum, thereby causing conception, and described some of the conditions which can prevent fertilization such as: Immunity of the female ovum to the male sperm, abnormal sperm formation in infertile men, tight tube openings in women, and insufficient sperm production on the part of the man.



Highlight of the second day of the conference was a discussion of the "Use of Rh Immunoglobulin in Hemolytic Disease of the Newborn," by John G. Gorman, M.D., director of the blood bank at the Presbyterian Hospital in New York City.

"If there is one point I would like to get across today," said Doctor Gorman, "is that the initial event which starts the disease has happened a year or more before the mother comes to the hospital."

Doctor Gorman, in conjunction with other researchers, has been able to prevent this disease event from occurring through the injection of Rh Immunoglobulin. He explained the problem arises when an Rh negative mother has an Rh positive child. In the last stages of her pregnancy, many of the Rh positive blood cells can pass into the mother's body. Her response will be to form antibodies to protect her blood stream against the incompatible cells. The danger comes when those antibodies are passed into the body of the child and attack his blood cells. Anemia, brain damage, jaundice, and still birth can result. Usually the first pregnancy would not be involved because the sensitization of the mother is most likely to occur at the time of delivery. Each additional pregnancy adds another 10% chance of developing sensitization in the mother.

To prevent the mother from forming antibodies in the latter stages of pregnancy, Rh immunoglobulin, called RhoGAM, is injected. RhoGAM is made from human plasma. "A sensitized mother that has had several stillborn babies is the best donor to help other mothers," says Doctor Gorman.

The immunoglobulin contains Rh antibodies which, for reasons which are not yet perfectly clear, prevent the mother from forming her own antibodies. The danger to subsequent children is present only when the mother is sensitized by Rh antibodies which she herself has produced.

Doctor Gorman explained further that the clinical breakthrough in the development of RhoGAM came in the early 1960s when a group of Rh negative prisoners at Sing Sing were tested. 18 of the prisoners were injected with Rh positive blood. 12 of them developed an immunity through the production of antibodies by their own bloodstream. The rest, injected with Rh positive blood and RhoGam, which already contained Rh antibodies, did not develop the immunity. This test proved that RhoGam could prevent the sensitization to Rh positive blood which is so dangerous when it occurs in child-bearing women.

Since then, clinical trials involving more than 3,000 women in 42 cities, including Ann Arbor, Grand Rapids, and Detroit, have been carried out with an astonishing degree of success. Manufactured by Ortho Pharmaceutical Company, approval of RhoGam by the National Institute of Health is expected in the very near future. □

MICHIGAN
STATE
MEDICAL
SOCIETY

NEW MSMS MEMBERSHIP

MSMS now has available a gold-filled Official MSMS Membership Pin for use in the coat lapel, as a tie tack, etc. Send check made out to MSMS for $3.00 to Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

MSU Reveals Plans For Medical Center

A citywide regional medical center, involving cooperative arrangements between Lansing area hospitals and a health center at Michigan State University, may be in Lansing's future, according to Andrew D. Hunt, Jr., M.D., dean of MSU's College of Human Medicine.

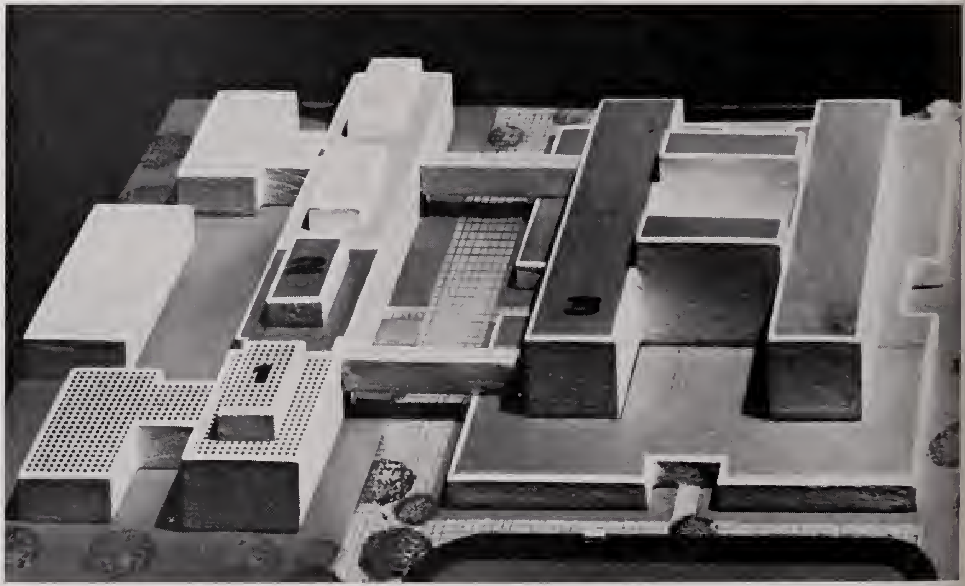
"This trend of the Lansing hospitals to develop as a medical center," said Dean Hunt at a Lansing Area Health Facilities Planning Council meeting, "suggests a model of cooperative community arrangements which will stimulate an increasing number of referrals from elsewhere, and strengthen the capacity of local physicians and hospitals to serve the community."

Through informal planning, Lansing hospitals have emphasized different areas of medicine, Dean Hunt said, so that "the opportunity exists for patients to be referred to one hospital or another for specific purposes."

The health center which MSU is planning, Doctor Hunt continued, will complement rather than duplicate specialized services already offered in the area. It will be located south of present campus buildings, between Hagadorn Road and Bogue Street extended.

First priority in the health center, he said, is a Life Sciences Building which will permit MSU to expand its current two year medical school enrollment from 26 to 64 students.

To become a four year medical degree-granting program two additional buildings will be needed — a Life Sciences II Building and the University Health Center Building.



The health complex for MSU, shown above, would include a Life Sciences Building (1) to permit MSU to expand its present two-year medical program from 26 to 64 students in each class, and would house the Department of Pharmacology and the School of Nursing, permitting expanded enrollments in these areas as well; Life Sciences II (2) to house additional science departments, and the University Health Center (3) would combine a hospital, an outpatient center and a student health service and would be designed specifically for teaching and research. Estimated costs are $10 million for Life Sciences I, $8 million for Life Sciences II and $15 million for the University Health Center. Half or more of the construction costs is potentially available in matching funds from the federal government. Unnumbered blocks represent a science library and possible additions to Life Sciences.

When it's more than a bad cold

your patient can feel better
while she's getting better

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle
327-8

Reporting of Medical Evidence On a Social Security Disability Applicant

BY DAVID P. GAGE, M.D.,
LANSING

The Arthritides

There are many requests made to physicians for medical information either on a patient whom they have been seeing or one whom they will be seeing. The type of report given by any one physician is quite variable and the medical documentation of a case where the patient has applied for disability insurance benefits from Social Security need not follow any set pattern nor formula.

The reporting physician must decide in each particular case what facts need be obtained and reported to support his clinical appraisal of the patient's disease, the medical outlook for the future, and his ability to function.

Any attempt to follow an outline could be a poor replacement of the knowledge and art that permits a professional judgment.

History

If, however, one did wish to record rather completely the history of an individual with some form of arthritis, for example, he would recount in the description of present illness, the date of onset of initial symptoms, the rapidity of development and progression of symptoms including, where applicable, the characteristic of pain, swelling, fatigue, weakness, morning stiffness and limitations of motion that restrict the daily activities of the individual. Where the disease pattern remits and relapses this should be noted. Any associated symptoms such as fever, weight loss, fractures and loss of appetite would be relevant. It is often very helpful to know how well or poorly the patient has responded to drugs of various kinds. Previous clinical studies should be noted also.

The family history as well as the vocational history is often of great value, particularly the latter including a comment on his most recent occupation and ability to work regularly.

Physical Examination

The physical examination would, of course, follow the routine which the examining physician has established as his pattern but should be prefaced by noting patient's posture, gait, nutrition and the use of assistive devices. It is always helpful to have a positive comment on the status of the peripheral vessel pulsations and a routine neurologic exam including description of the mental state, sensory and motor functions, abnormalities noted, etc.

If one has need to describe certain joints the description should note presence of local heat, nodules and the condition of overlying skin and subcutaneous tissue. The associated muscle changes, especially the location and degree, can include notation of atrophy, spasms, contractures, etc. where present. If there is a change in joint size it should be related to the presence of fluid, bony overgrowth, thickening of joint membrane and degree of tenderness in the joint. Deformity and shortening of a joint is significant, as is the range of motion where limitation, particularly due to pain, ankylosis and spasm exists. Where joint mobility is involved some comment on the patient's ability to stand, walk, bend, stoop, crouch, sit, climb stairs, pinch, grip, reach, type, dress and undress, is in order.

Laboratory

In the laboratory area there would ordinarily be considerable variation, but a few basic tests which generally help are blood count, urinalysis, and x-ray of several involved joints. Some cases will require additional laboratory studies and the ones often very helpful are determination of rheumatoid factor, uric acid, the LE prep and antistreptolysin titre. Other blood chemistries can be extremely helpful, including BUN, calcium-phosphorus levels and the total protein with A/G ratio. The usual serology should be included,

---

Doctor Gage is Chief Medical Consultant, Disability Determination Service, Division of Vocational Rehabilitation, State Department of Education.

ECG and sometimes ventilatory function studies may be indicated.

Diagnostic, Prognostic and Functional Conclusions

If the examiner cares to submit an *anatomic* classification this can be coded as of a given stage (I - IV), and the *functional* classification can be graded from class 1 to 4, as provided by the American Rheumatic Association.

In subsequent contributions to the Journal I would like to touch on several other body systems in which a review of the supporting data might be helpful.

The treating physician plays a significant role in helping us to make disability determinations that are medically sound, and with our vocational evidence assure this patient an equitable decision. Our Social Security—Vocational Rehabilitation team can provide speakers to discuss the adjudication process and Social Security coverage for physicians. If your local society or group is interested, please call or write: Disability Determination Service, Division of Vocational Rehabilitation, Department of Education, Box 1200, Lansing, Michigan 48904; or phone area code 517-373-3380.

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

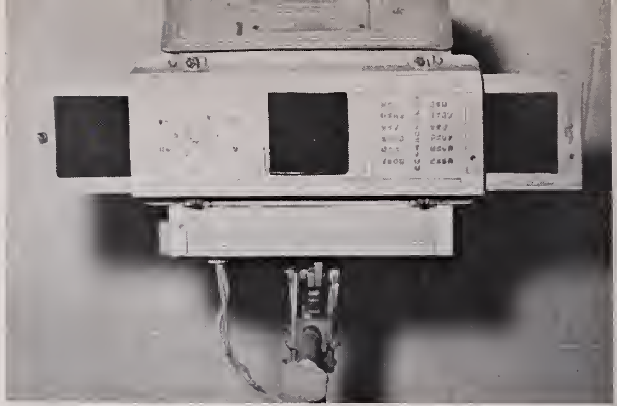
FOR THE FOUR-WEEK PERIOD ENDING MARCH 29, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	36	174	121	498
Whooping Cough	28	86	132	280
Diphtheria	0	0	0	0
Mumps	2,389	2,158	7,297	5,938
Scarlet Fever & Strep Sore Throat	1,414	1,856	4,098	5,620
Tetanus	0	0	1	0
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	140	154	461	625
Salmonellosis (Other than S. typhi)	72	47	166	150
Typhoid Fever (S. typhi)	0	0	0	1
Shigellosis	16	33	49	120
Aseptic Meningitis	9	1	18	4
Encephalitis	5	7	28	24
Meningococcic Meningitis	6	1	30	14
Influenzal Meningitis	3	0	14	9
Tuberculosis	262	284	775	795
Syphilis	371	596	1,416	1,612
Gonorrhea	1,186	1,474	4,161	4,030

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

All these items are declared medically worthless by the Food and Drug Administration. The "Slenderoll" supposedly helped roll off excess poundage. "Sea Brine," or minerally enriched ocean water, is an old favorite with swindlers. "Laetrile" was potentially more dangerous because it claimed to destroy cancerous cells. The "Electro-Galvanic" bracelet, selling for $22.50 "cured" sciatica and arthritis. "Visan," a nutritional food supplement, was recommended for "mental confusion, cerebral palsy, blindness, multiple sclerosis, diabetes, etc."



A notorious quack device, the "Spectrochrome" allegedly cured 150 major diseases with light from an ordinary light bulb shining through colored glass slides. Cancer was "cured" by moving purple and blue slides in front of the light; heart disease was "cured" by using the red and purple slides. Before its confiscation, some patients had died.

When You See a Quack - Tell Your Patients to Duck

Editor's Note: The following article is reprinted with permission from Highlights, the publication of Michigan Blue Shield-Blue Cross for employees. The article is printed here to provide physicians more information and insights into quackery, as MSMS moves during 1968 into a strong educational-quackery program across the state with component medical societies.

What is a quack? In defining the word, dictionaries use such synonyms as "fraud, faker, pretender, a practitioner of deceit." The medical quack is most easily described by what he is not.

The legitimate practice of medicine is carried on by men and women who have spent ten years or more in study and preparation. After leaving college they go to medical schools, then into hospitals for internship and postgraduate training where they are under the direction of highly trained and experienced instructors. The necessity of being sure, being right, testing again and again, seeking other informed opinions, questioning and searching is continually emphasized.

THE QUACK IS NOT a professional, neither in medical training nor in medical ethics. The outright criminal quack knows his medicine or treatment of whatever sort is worthless. He is out to milk money from persons who are ill, often with incurable diseases, and he does it without any qualm of conscience. It is his way of making a living and nothing more than that—from his point of view.

The quack lectures and travels and advertises, showing testimonials from "cured" patients—who probably did not have the disease to start with. He is usually glib in speech and affable in manner. He frequently displays forged licenses and diplomas.

USUALLY THE QUACK CLAIMS he can treat organic disease by a special secret method or by a certain product. He may pretend to have special cures for arthritis, diabetes, tuberculosis, cancer, feeblemindedness or other serious conditions. Believing only what they are told by a pitchman or health lecturer, millions of people each year attempt self-medication for their self-diagnosed symptoms. Countless more, some with confirmed illnesses, are beguiled with assurances of a quick cure, even for incurable diseases.

Honest medicine cannot always give such assurances. The quack, unhindered by professional ethics or personal concern, can and does promise cures he knows he cannot possibly deliver. Just as bad, the quack often negates much of the good that medicine can do or was doing. He steals pre-

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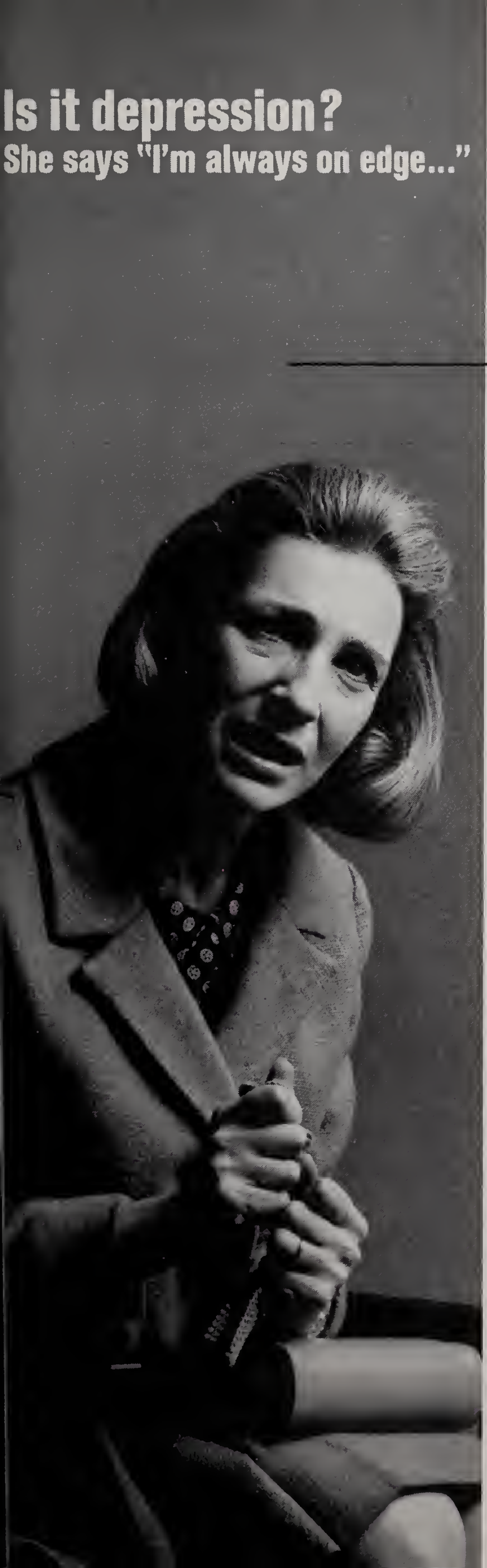

Is it depression?
She says "I'm always on edge..."

...but her other symptoms:
depressed mood, insomnia,
anorexia, feelings of guilt
strongly suggest
an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

MERCK SHARP & DOHME Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

cious time—that early period of a disease when prompt, efficient treatment can easily mark the difference between life and death.

Today quackery is a big business. Accurate figures are difficult to obtain, but experts estimate that Americans spend ONE BILLION DOLLARS each year (45 million dollars in Michigan alone) on useless cures, mechanical gadgets, fad foods and other quack remedies.

The solution to the quackery trade is not simple. In fact, the prosecution of frauds perpetrated in the guise of medicine is extremely difficult. Just as a hypochondriac imagines disease, so can the gullible unthinking person imagine cures, even when disease still exists.

TO HELP THE PUBLIC spot quacks, the U. S. Food and Drug Administration in Detroit offers this check list of six points. He is probably a quack if:

1. He uses a special or "secret" machine or formula he claims can cure disease.
2. He guarantees a quick cure.
3. He advertises case histories and testimonials to promote his cure.
4. He clamors constantly for medical investigation and recognition.
5. He claims medical men are persecuting him or are afraid of his competition.
6. He tells you that surgery or x-rays or drugs will cause more harm than good. ☐

Michigan Statistics Re The Health Team

* Number of Graduates of Programs in Selected Health Professions, 1966

263	Medicine and Osteopathy
143	Dentistry
1,278	Nursing, RN, Total
244	Nursing, Baccalaureate
876	Nursing, Diploma
158	Nursing, Associate
1,479	Practical Nursing

* Graduates of Programs in Selected Health Professions per 100,000 Population

8,374	Population 1,000's
3.1	Medicine and Osteopathy
1.7	Dentistry
15.3	Nursing, RN, Total
2.9	Nursing, Baccalaureate
10.5	Nursing, Diploma
1.9	Nursing, Associate
17.7	Practical Nursing

* Public Health Service Publication, #1667
"Health Manpower, Perspective 1967"
U. S. Government Printing Office, 55¢

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road   Conducted by Sisters of Mercy   Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

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* 1904 - 1967

SPECIAL FOUR-PAGE SECTION:

Explain Efforts of Michigan Council on Smoking and Health

The Surgeon General's Office of the United States Public Health Service has recently released a three-year follow-up on smoking and disease entitled, *The Health Consequences of Smoking*. The 1967 report represents a review of more than 2,000 research studies published since the 1964 report.

These additional studies confirm and strengthen the conclusion of the Surgeon General's Advisory Committee that: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."

SINCE THE RELEASE of the Surgeon General's Report on Smoking in 1964, some progress has been made in educating Americans, especially the young, to the dangers of smoking. The progress has been in the following areas:

1. Seven out of ten people know smoking is a health hazard.
2. There are 19,000,000 ex-smokers.
3. One million people quit each year. (Unfortunately these are, roughly, replaced by youth who take up the practice.)
4. One-fourth of the men and one-fifth of the women who once smoked have quit.
5. One-third of those who try to quit do make it.
6. The percentage of physicians who smoke has dropped from 60 in 1960 to less than 25 now, in 1967.
7. Some college project directors report less smoking among entering freshmen than in past years.
8. Recently federal tax administrators said that the 2.5 per cent increase in cigarette sales last year reflected little increase in per capita cigarette usage and that per capita consumption had declined in twenty-two states and the District of Columbia.
9. Some insurance companies now are giving lower rates to nonsmokers.
10. Several magazines no longer accept cigarette advertising.
11. A few airlines have stopped distributing cigarettes with meals.

IN MICHIGAN, MUCH of this work is being carried out by the Michigan Council on Smoking and Health and its 16 member agencies and organizations. The Michigan Council on Smoking and Health is an active interagency organization concerned with focusing public attention on the problem of cigarette smoking and disease and coordinating the efforts of its member organizations. As a physician, you are probably familiar with most of these organizations and may have served these organizations as a resource person or board member. The sixteen organizations are:

1. Michigan State Medical Society
2. Michigan Youth Commission
3. Michigan Association of Secondary School Principals
4. Michigan Cancer Foundation
5. Michigan Congress of Parents and Teachers
6. Michigan Department of Education
7. Michigan Department of Public Health
8. Michigan Education Association
9. Michigan Health Council
10. Michigan Heart Association
11. Michigan School Health Association
12. Michigan School Nurses Association
13. Michigan State Dental Association
14. American Cancer Society—Michigan Division
15. Michigan Tuberculosis and Respiratory Disease Association
16. Michigan Association of Osteopathic Physicians and Surgeons

THE OBJECTIVES OF the Michigan Council on Smoking and Health are:

1. To coordinate, when appropriate and desirable, the smoking educational programs of organizations interested in smoking and its relationship to health and disease;
2. To promote and assist where appropriate in the development of regional and local councils in Michigan;
3. To promote education as the primary means of favorably influencing youth and adults regarding their decisions on smoking;
4. To stimulate the production and utilization of appropriate resource materials;

5. To encourage the utilization of research and research findings in all areas related to the impact of smoking on health and disease;
6. To collect and disseminate factual information about the relationship of smoking to health and disease.

THE MICHIGAN COUNCIL on Smoking and Health is concerned primarily with public education. Key groups that the Michigan Council is trying to reach are youth, parents, teachers and physicians. Local programs that you should be alert to in 1968 are cooperative programs with:

1. **YOUTH:** Cooperative project with the Michigan Youth Commission, the official governmental agency representing the 41 major youth-serving agencies and organizations. YAC — Youth Advisory Committee — of the Michigan Youth Commission is interested in a youth-to-youth program to discourage smoking among young people.
2. **PARENTS:**
   a. COOPERATIVE PROJECT WITH PTA: Cooperative project with Michigan Congress of Parents and Teachers — second year. Last year, we completed Phase I of the National PTA Parent to Parent Program that was concerned with *orientation* of parents to the smoking and health problem among youth. This year the emphasis will be upon developing action programs among local PTAs in reducing the incidence of smoking among young people.
   b. COOPERATIVE PROJECT WITH CHILD STUDY CLUBS: Assisting the state organization to develop a study resource unit on smoking and health that can be used by all Child Study Clubs in Michigan.
3. **TEACHERS:** Cooperative project with Michigan Department of Education. Implementation of National Education Association program to strengthen health education instruction in the school with emphasis upon the problem of smoking and health.
4. **PHYSICIANS:**
   a. MICHIGAN STATE MEDICAL SOCIETY: The Michigan State Medical Society Public Relations Committee is charged with responsibility of studying the problem of smoking and health and making recommendations for action to the State and County Medical Societies.
   b. MICHIGAN ACADEMY OF GENERAL PRACTICE: Request to assist the Michigan Academy in organizing a series of one-day workshops on the topic of smoking and health. Physicians attending would receive Category I credit.

SPECIFICALLY, WHAT CAN you do as an individual in this state-wide program to reduce illness and disability connected with cigarette smoking:

1. Familiarize yourself with the latest information on smoking and disease and the most effective techniques for discouraging smoking;
2. Make a motion that your local county medical society have a program on smoking and disease; and
3. Assist groups in your local community like the PTA and youth-serving agencies in carrying out educational programs on smoking and disease.

AS A FIRST STEP, we urge you to look over the materials available for physicians and patients on this topic which are illustrated on the next page and available to you without cost. Please indicate the materials that you want and the quantity desired on the attached self-addressed, stamped postcard.

The Michigan Council on Smoking and Health is actively engaged in promoting smoking education through programs of

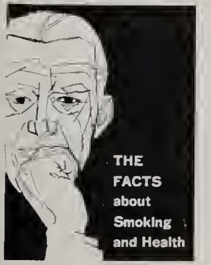
- **— In-school information**
- **— Withdrawal clinics**
- **— Circulation of films**
- **— Materials**
- **— Workshops for teacher education**
- **— Establishment of local councils**
- **— Media information for Press, Radio, TV**

THESE EIGHT ARE ESPECIALLY FOR THE PHYSICIAN . . .

smoking and illness
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

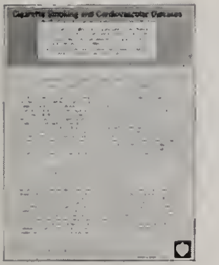
1. Smoking and Illness

U.S. Public Health Service
Pamphlet summarizing survey conducted by National Center for Health Statistics on relationship between cigarette smoking and general health.


THE FACTS about Smoking and Health

2. The Facts About Smoking and Health

U.S. Public Health Service
A pamphlet summarizing the results of the new Surgeon General's Report of 1967 on smoking and health.


Cigarette Smoking and Cardiovascular Diseases

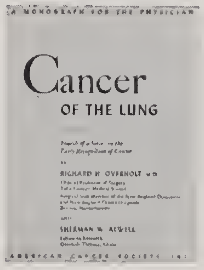
3. Cigarette Smoking and Cardiovascular Diseases

Michigan Heart Association
A reprint summarizing the American Heart Association Scientific Committee study of the smoking and health problem.

LUNG CANCER PREVENTION AND THE PHYSICIAN

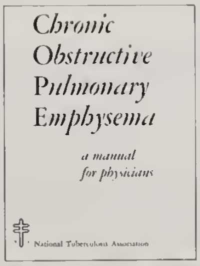
4. Lung Cancer Prevention and the Physician

A pamphlet summarizing statisti-
American Cancer Society—Mich. Div.
cal data on the relationship of cigarette smoking to lung cancer.


A MONOGRAPH FOR THE PHYSICIAN
Cancer OF THE LUNG
RICHARD H. OVERHOLT M.D.
SHERMAN W. ATWELL
AMERICAN CANCER SOCIETY INC.

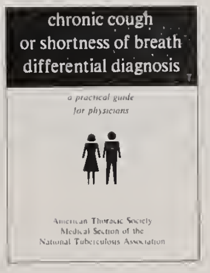
5. Cancer of the Lung

American Cancer Society, Mich. Div.
A 52-page monograph for physicians on diagnostic procedures for early recognition of lung cancer.


Chronic Obstructive Pulmonary Emphysema
a manual for physicians
National Tuberculosis Association

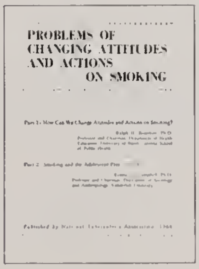
6. Chronic Obstructive Pulmonary Emphysema

Michigan Tuberculosis and Respiratory Disease Association
A 56-page manual for physicians on diagnosis and treatment of this disease.


chronic cough or shortness of breath differential diagnosis
a practical guide for physicians
American Thoracic Society
Medical Section of the
National Tuberculosis Association

7. Chronic Cough or Shortness of Breath — Differential Diagnosis

Michigan Tuberculosis and Respiratory Disease Association
A 14-page pamphlet for physicians on differential diagnosis of this problem.


PROBLEMS OF CHANGING ATTITUDES AND ACTIONS ON SMOKING

8. Problems of Changing Attitudes and Actions on Smoking

Michigan Tuberculosis and Respiratory Disease Association
A pamphlet with concrete suggestions for getting patients to stop smoking.

Michigan Council on Smoking and Health:

Gentlemen:

Yes, I want copies of your publications on smoking and disease. I understand the publications will be furnished at no charge by the member agencies of the Michigan Council as part of the public educational effort.

Please send me the following materials I have checked in the quantity requested to:

NAME ____________________

STREET ____________________

CITY ____________________ ZIP ____________

☐ 1 ________
☐ 2 ________
☐ 3 ________
☐ 4 ________
☐ 5 ________
☐ 6 ________
☐ 7 ________
☐ 8 ________
☐ 9 ________
☐ 10 ________
☐ 11 ________
☐ 12 ________
☐ 13 ________
☐ 14 ________
☐ 15 ________
☐ 16 ________

THESE CAN BE DISTRIBUTED TO PATIENTS . . .

100,000 doctors have quit smoking cigarettes.
(Maybe they know something you don't.)

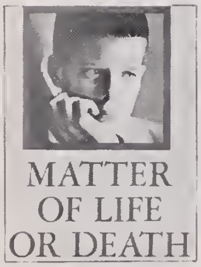
9. Poster for Physician's Office

(100,000 Doctors Have Quit Smoking)
U.S. Public Health Service
An attractive 8½ x 11 inch black and white poster suitable for display in physician's office.

What We Know About

10. What We Know About Children and Smoking

U.S. Public Health Service
A pamphlet describing why children start smoking and what adults can do so help children from starting.


MATTER OF LIFE OR DEATH

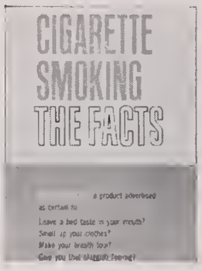
11. A Matter of Life or Death

Michigan Congress of
Parents & Teachers
A pamphlet explaining the dangers of cigarette smoking for young people and what parents can do.

"Who, me? Quit smoking?
After all those years of cigarettes!
What's the use?"

12. Who Me? . . . Quit Smoking?

American Cancer Society—Mich. Div.
A pamphlet explaining why an adult should stop smoking and what can be done to "kick the habit."


CIGARETTE SMOKING THE FACTS
a product advertised as certain to
Leave a bad taste in your mouth?
Smell up your clothes?
Make your breath toxic?
Give you that sluggish feeling?

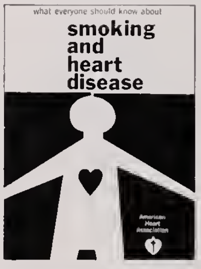
13. Cigarette Smoking — The Facts

Michigan Tuberculosis and
Respiratory Disease Association
A pamphlet discussing the health hazards of smoking, why people go on smoking, and what can be done about this problem.

the Great Imitators

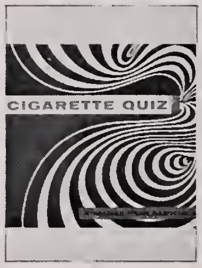
14. The Great Imitators

American Cancer Society—Mich. Div.
A pamphlet showing how children imitate parents' smoking behavior and what parents can do to discourage this practice.


what everyone should know about
smoking and heart disease
American Heart Association

15. Smoking and Heart Disease

Michigan Heart Association
A pamphlet showing the relationship between cigarette smoking and heart disease.


CIGARETTE QUIZ

16. Cigarette Quiz

Michigan Heart Association
A pamphlet testing your I.Q. on smoking with answers and discussion for each question.

Doctor, please send this easy order blank to:

MICHIGAN COUNCIL ON SMOKING AND HEALTH
% MICHIGAN HEALTH COUNCIL
712 ABBOTT ROAD
EAST LANSING, MICHIGAN 48823

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Vacation trip....

Motion sickness?

This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

BY H. A. TOWSLEY, M.D.
PRESIDENT, MICHIGAN HEALTH COUNCIL

Michigan Health Council Stresses Health Careers

The approach of Florence Nightingale's Birthday (May 12) and National Hospital Week (May 12-18) focuses attention on the need for more nurses and other health personnel.

There is scarcely a hospital, nursing home or medical center in the United States that is without a "Help Wanted" sign. These health care institutions are having to make do with the trained personnel they have or are recruiting from each other short-in-supply health personnel.

In spite of the nation-wide effort to promote careers in health and the thousands of articles that have appeared in newspapers and magazines in recent months, there still are many misconceptions about careers in health. I would like to address myself to some of them.

Entering a health occupation means being a physician or nurse.

This is no longer true. A century ago about 91 out of every 100 persons in a health profession were doctors of medicine, now the picture has changed completely and only nine out of every 100 persons presently engaged in health services is a physician. There are more than 300,000 physicians and over 3,500,000 men and women involved in health services in the United States. Thirty-seven of every one hundred are in other kinds of professional and technological health careers such as dentistry, pharmacy, nursing, medical technology, etc.; about the same number are in service and maintenance health occupations; and the remaining seventeen are administrators and office workers in hospitals, etc.

The Health Service Industry is America's fastest growing industry. There now are more than 200 job classifications, and new careers join the list every year. A generation ago, we had not heard of careers in inhalation therapy, nuclear medical technology or hospital unit management. What's more, the old health careers have taken on a new look. Many nurses today do not see the inside of a hospital except when they, themselves, are sick. Thousands are working full time as school nurses, industrial nurses, public health nurses and home care nurses with visiting nurse associations. Hundreds of nurses serve on faculties in Michigan community colleges training student nurses.

Many young men and women finishing training in veterinary medicine and pharmacy are going into research or pharmaceutical sales rather than following the customary procedure of a generation ago of practicing their profession in farming areas or in a corner drug store.

A minimum of a bachelor degree now is necessary preparation for a health career.

Not true. Health careers are so varied that education needed to enter them is varied, too, ranging all the way from a high school education to several years of post-graduate study. Here are some examples of careers requiring less than four years of college.

The nurse aide, orderly or psychiatric attendant can receive on-the-job training which may take up to three months. They perform many routine tasks of patient care, thus relieving the nursing staff for more complex duties.

The licensed practical nurse, the inhalation therapist, the electrocardiograph technician, and the surgical technical aide receive special training for their positions. This training usually is completed in one year.

Training in many careers in medical and dental offices as well as in hospitals may be obtained in two years or less. The certified laboratory technical assistant needs a high school education plus a year's training in an approved school. The medical assistant and dental assistant may obtain their training in one to two years. Dozens of other health occupation curriculums are in the one-to-two-year programs.

"I can't get the training I want here in Michigan."

False. Michigan has been a leader in developing new health occupations education programs, and there now are more than 50 health career curriculums being offered in 116 Michigan universities, colleges and hospitals. These careers range from that of an anatomist to a Vocational Rehabilitation Counselor. Let's take a look at what education programs Michigan now offers the young men and women seeking a career in health.

The Big Three in Education in Michigan also are the Big Three in providing medical and allied health curriculums. The University of Michigan now offers 25 different educational programs in medical, dental and allied health careers while Wayne State University with 20 and Michigan State University with 18 are close behind. All three now offer programs in medicine, nursing, medical technology, biology, dietetics, anatomy, audiology and speech and hearing therapy. Both the University of Michigan and Wayne State University train physical therapists and pharmacists while Michigan State University is the school in Michigan training veterinarians.

The University of Michigan and the University of Detroit are among the largest schools of dentistry in the United States and also train most of the dental hygienists in Michigan. Ferris State College is next in line in providing health career curriculums in pharmacy, dental assisting, dental hygiene, environmental health sanitation, environmental health assisting, food technology, medical assisting, medical technology, optical technology, radiologic technology. Several new health career curriculums such as associate degree nursing, medical record technology, radiation health technology and pesticide technology are being scheduled at Ferris for the Fall of 1968.

Students interested in medical technology may obtain their preparation in every area of Michigan, because there are 50 different colleges and hospitals that provide classroom and clinical facilities for this profession. Among the schools adding new health careers curriculums during the past five years are such state universities and colleges as Eastern, Western, Central, Michigan Technological and Lake Superior State College and such privately supported colleges as Alma, Olivet, Mercy and others. Northwood Institute at Midland is pioneering a new health curriculum known as the hospital unit manager program. This two-year curriculum will enable hospitals to have a well-trained person take over many of the non-nursing functions in the hospital thus permitting registered nurses to spend a greater share of their time on patient care.

"I can't afford an education for a health career."

Not true. A student who really has the desire and qualifications to become a doctor or a member of one of the other health professions can attain his or her goal regardless of his financial situation. There are many voluntary organizations such as the United Cerebral Palsy Association that provide loans and scholarships for students interested in rehabilitation careers, and loans and scholarships for students in need of financial help also are available through our colleges, hospitals and other institutions.

The AMA offers a splendid loan program for medical students, and tens of thousands of young doctors have obtained their training through this program.

The State of Michigan and the Federal Government now offer loan and scholarship programs for students taking many of the health occupations. Students can start repaying the loan after they finish their education and in some programs as much as half of the loan will be written off if the person practices his profession for five years or longer. The C. S. Mott Foundation of Flint will provide funds for young men and women in Michigan's Upper Peninsula who want to go to medical school but need financial assistance because of family circumstances. The Foundation also will help students in some of the other health occupations.

The Michigan Health Council will be glad to assist students interested in exploring the availability of scholarship or loan funds, or the student may communicate directly with his guidance counselor or the college, hospital or other institution they contemplate attending to learn of available financial aid.

"I don't know where to write for health careers information."

The Michigan Health Council, P. O. Box 431, East Lansing, Michigan 48823, will provide any Michigan young person, counselor or other interested individual with a free copy of "Horizons Unlimited," a publication of the American Medical Association telling about most of the health occupations. Through the cooperation of MHC and the Michigan State Medical Society, a special section lists all of the health occupations taught in Michigan and explains where a student may obtain his training. It also lists professional organizations that can provide detailed information on health occupations, scholarships, etc.

"Health Careers Guidebook" is another splendid publication. It is available for $1.50 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. This book contains briefings on more than 200 different health careers, with addresses to which to write for further information.

A great deal of information on both professional and practical nursing is available from the Michigan League for Nursing, 51 West Warren, Detroit, Michigan 48201.

Horizons Unlimited

MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

ONE MORE MISCONCEPTION — perhaps the most subtle of all — remains concerning health careers. It is the idea that as more and more new machines, drugs, devices and techniques are developed in the field of medicine, health personnel somehow become less important. Nothing is farther from the truth. We can't program computers to be concerned about human beings. More than ever before, we need people in the health professions who have compassion and sympathy for others, who really care enough about those they help to get involved and provide them with the best possible health care and services. ☐

Says Programs In Sex Education Need MD Support

"The support of the medical profession is needed as local boards of education explore the needs and develop K-12 programs in sex education," declared Frederick J. Margolis, M.D., Kalamazoo, in his remarks at a recent meeting in Midland with leaders of the Midland County Medical Society.

Doctor Margolis narrated his film, "Parent to Child about Sex" and led discussion for 500 parents and teachers at an evening community program.

Doctor Margolis observed that a school board will have difficulty moving forward in sex education without the support of the local physicians and medical society.

"Communities interested in improving sex education," Doctor Margolis said, "can establish a large, representative 'Community Council for Sex Education.' " "Sex education," he said, "must be a responsibility of the home and church, but the schools provide the best opportunity to work effectively with all children. Hand-in-hand with better school programs, with the teachers assigned to build the curriculum, there should be adult education classes, workshops, etc.," he declared. ☐

STATE ANESTHESIOLOGISTS SELECT LEADERS

Shirley Austin, M.D., Detroit, is the new Chairman of the Michigan Society of Anesthesiologists. John F. Coleman, M.D., Traverse City, was elected vice-chairman and Ralph Bauer, M.D., Detroit, was re-elected secretary-treasurer.

The officers also serve as Section Officers in the Section of Anesthesiology.

Ralph Askam, M.D., Muskegon, is the delegate to the MSMS House of Delegates and Bernard Sivak, M.D., Southfield, is the alternate delegate for 1968 and 1969. ☐

Abbott Antihypertensive Building Blocks

A simplified approach
to the practical management
of hypertension

PIDINE
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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
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METHYCLO-
THIAZIDE
5 mg.

Excellent day-long Na$^+$ output, yet easy on the K$^+$

Enduron provides an excellent starting therapy. Your patient sodium excretion is greatly enhanced. Yet potassium loss is lov

The therapeutic action is smooth, and persists for a full 24 hour With Enduron you can prescribe convenient once-a-day dosa without skimping your patients on day-long thiazide effectivenes

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample most cases.

Once a day, every day
ENDURON®
METHYCLOTHIAZIDE

MILD
TO
MODERATE
TO
SEVE

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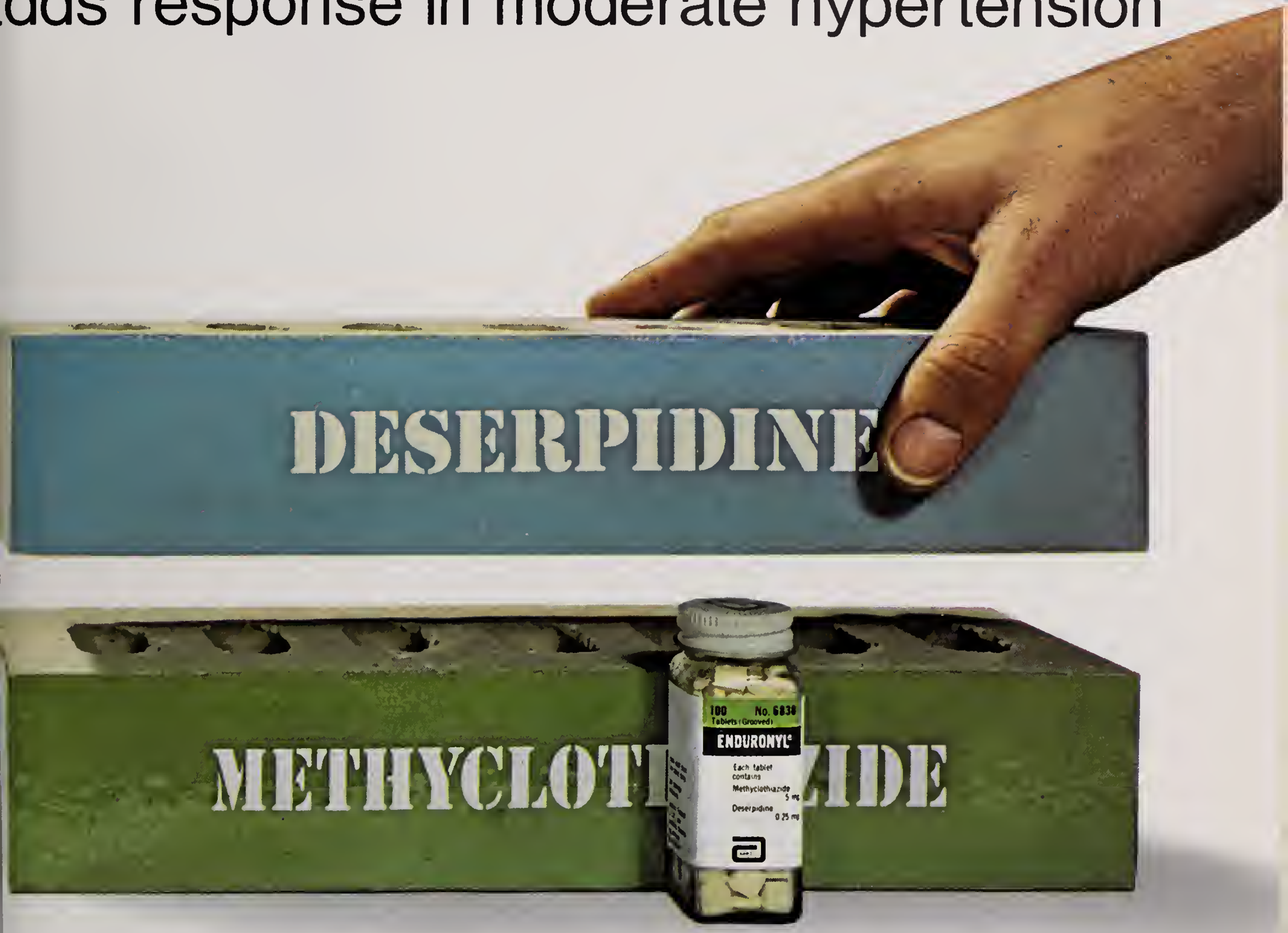
nduronyl: Its deserpidine component dds response in moderate hypertension


DESERPIDINE
METHYCLOT ZIDE
100 No. 6830
Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

ce a day, every day

NDURONYL®

HYCLOTHIAZIDE 5 mg. with
RPIDINE 0.25 mg. or (FORTE) 0.5 mg.

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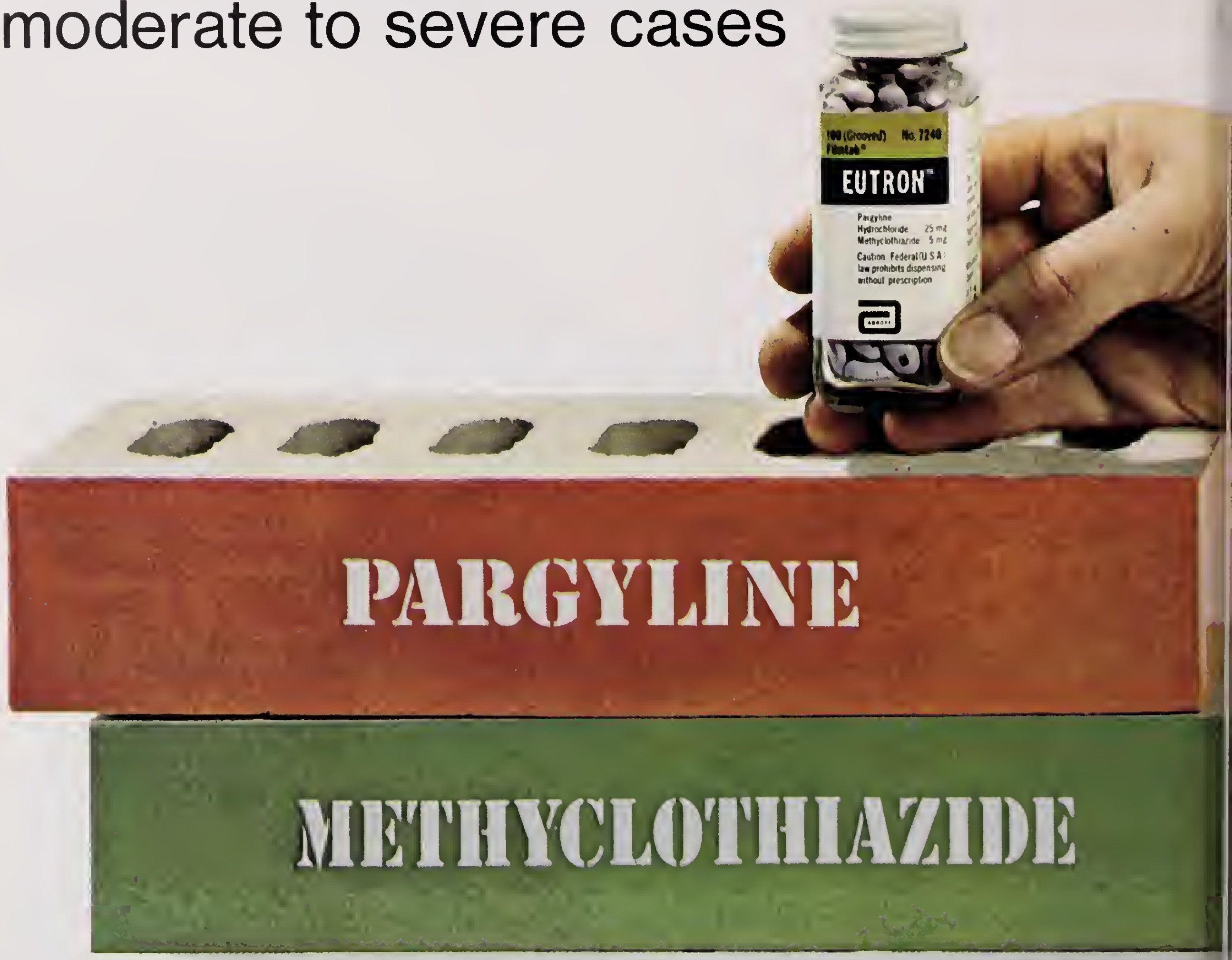
801094

Eutron: A unique combination for handling moderate to severe cases


100 (Grooved) No. 7240
Filmtab®
EUTRON™
Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal (U.S.A.) law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether yo patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings we reduced from 112 pre-treatment to 90 post-treatment; *sitting* fro 115 to 95; and *recumbent* from 112 to 94.

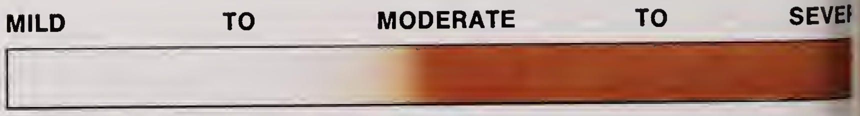
Note that following Eutron, the diastolic reductions were near alike in all three body positions.

Use Eutron for managing your moderate to severe cases. I building blocks enhance each other; hence lesser doses often suffic

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.


MILD
TO
MODERATE
TO
SEVE

See Brief Summary on final page of advertisement

80

ENDURON®
METHYCLOTHIAZIDE

ENDURONYL®
Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™
Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

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RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Beaumont Lecturer Explores the Brain

BY PETER HOHEISEL
OF THE MSMS STAFF

Pacing the platform of the Wayne County Medical Society auditorium and showing slides of monkeys and chimpanzees, José M. Delgado, M.D., 1968 Beaumont Lecturer, fascinated an audience of 300 people April 1 with the topic "Reaching for the Mind in the Depth of the Brain."

After tracing the erosion of the concept of man's earth as the center of the universe, man's race as a unique creation totally distinct from the other animals, and finally man's ego as a pre-existent, inwardly-given reality, Doctor Delgado expounded his thesis that "Today we can approach the mind; it isn't some mysterious, unreachable entity but rather it is memory, pleasure, and pain. All of these, and other mental functions, should have neural coordinates which we can investigate and modify."

The Yale physiologist has been investigating the brain, mainly in monkeys and chimpanzees, through the use of electrodes implanted in specific cerebral areas. He has developed what he calls the "Stimo-ceiver" which can both monitor and modify brain activity. In the slides of monkey and chimpanzee activity, Doctor Delgado illustrated how he can induce, through radio waves, aggression, friendliness, maternal rejection, running, and other physiological patterns.

"HOW IS BEHAVIOR organized in the brain? Where is anger? Love? Where are ideas? Emotions?

MD Placement Notice

—Looking for a smaller town that needs and wants a physician?

—Do you need an associate or assistant in your practice?

—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)
(No charge for this service)

These are the questions we are investigating," said Doctor Delgado.

"The neurophysiologist, however, must realize the limitation of what he is doing," Doctor Delgado cautioned. "We can only detect the material carrier of the information, not the symbolic meaning. Symbolic meaning depends on the process of cultural formation. The meaning that a glass is a glass is given by experience based on a temporal quality."

Speaking of his experiments with monkey and chimpanzee colonies, the Yale physiologist observed that "you can't talk of brain stimulation in absolute terms, but only in relation to the social group." He said stimulation can only affect preexistent patterns. It cannot create new ones. For example the number two monkey in a colony could be induced to be aggressive to number one, but a money who is lowest in social rank could not successfully challenge the authority of number one.

DOCTOR DELGADO CONCLUDED that up to now man's technological prowess has been devoted to conquering nature outside of himself: "We haven't tried to put the same energy into conquering our minds and our brains. The challenge of the future is the education of our minds and psyches."

When asked, however, whether human beings could be turned into robots through radio stimulation, the Yale physiologist replied that he did not think this was possible since the mind which invents instrumentation is infinitely more complex than the devices which it creates. □

Ask Physicians Help July 1 in VD Survey

All practicing physicians in Michigan and the nation will receive a federal questionnaire mailed on July 1 as part of a National Survey of VD Incidence.

In an effort to obtain an accurate measure of the severity of the VD problem in the United States, the AMA, the National Medical Association, the American Osteopathic Association and the American Social Health Association in cooperation with the Public Health Service will conduct the "National Survey of VD Incidence," which will cover the period from April 1 through June 30, 1968.

The tabulated results will be published nationally by the sponsoring organizations.

All medical societies have been requested to cooperate by urging physicians to participate in this survey. □

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Phenobarbital, Caution: May be habit forming	21 mg.
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Iodide contraindications: tuberculosis, pregnancy.

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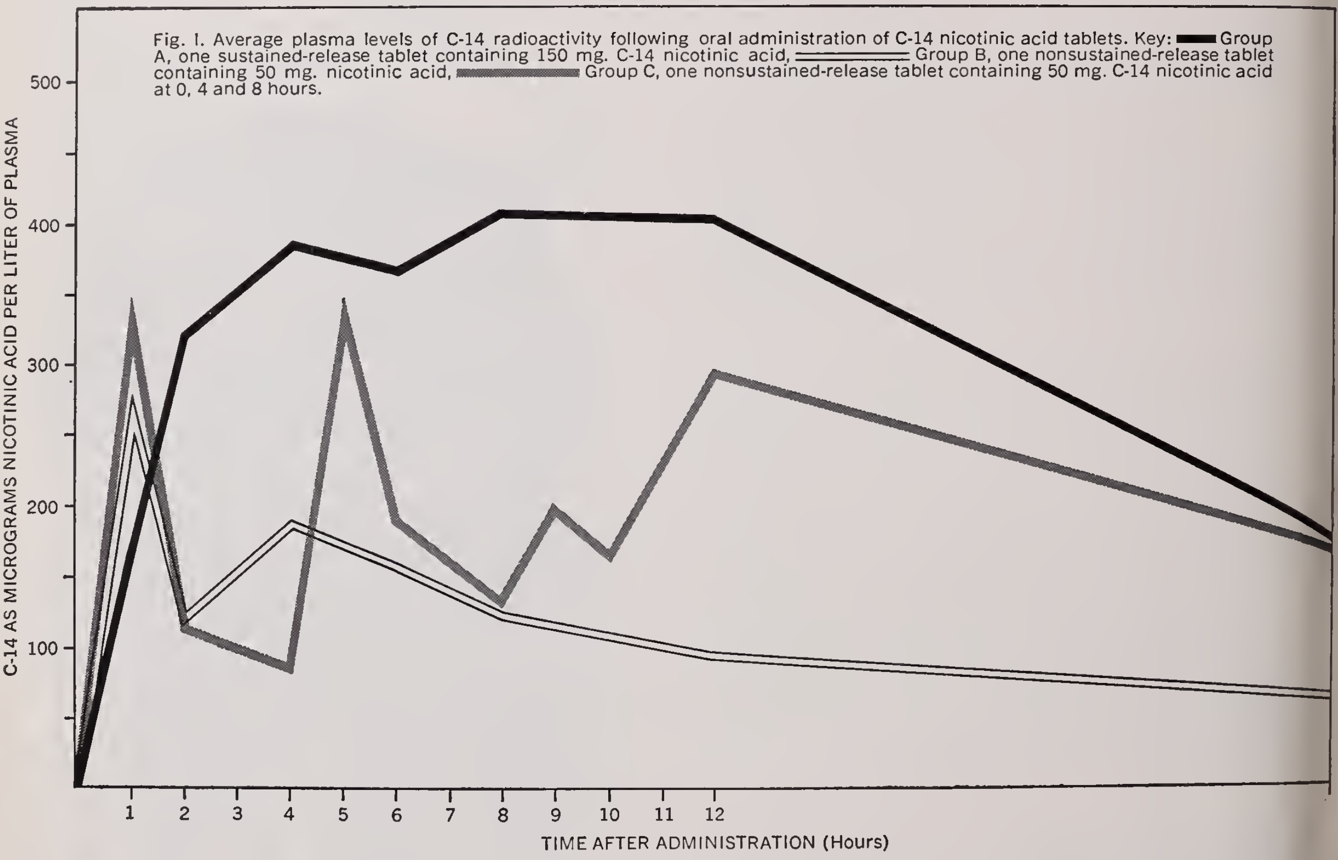

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazo TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Als cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more aler

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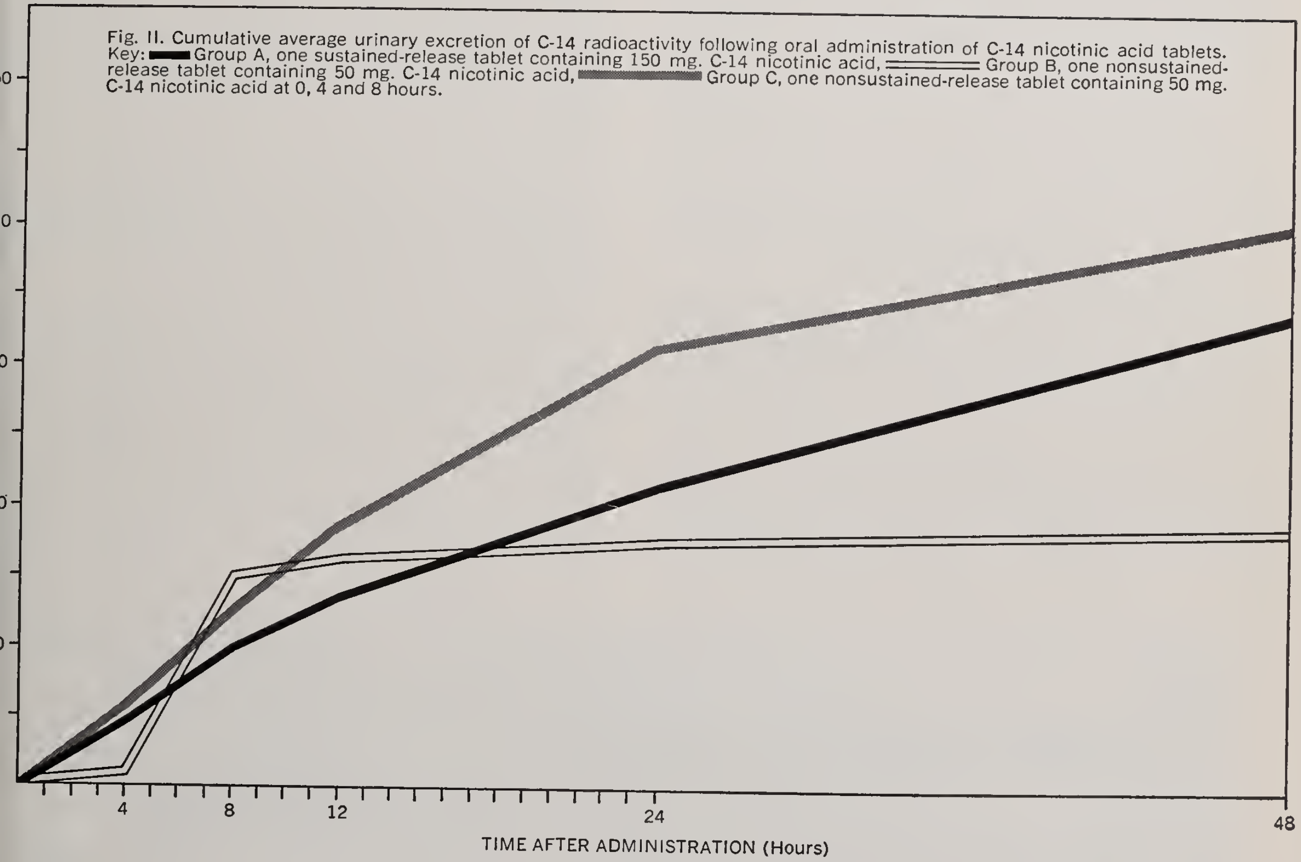

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

confused and moody. Personal care, memory, ional stability, social attention improve. Fatigue, hy and irritability are reduced.

prescription for 100 tablets of Geroniazol TT will iit your patients to enjoy the benefits of time-nged nicotinic acid/pentylenetetrazol therapy, economical price. Dosage is only one tablet every urs.

raindications: There are no known contraindica-

utions: Exercise caution when treating patients a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Some Questions and Answers About Hospital Accreditation . . .

Q. In a community with two nonteaching hospitals, with exactly the same staff in each hospital, would the Joint Commission consider joint sectional staff meetings, in order to help alleviate some of the demand put on physician's time?

A. While the Joint Commission is interested in conservation of physician time, the purpose of hospital staff or departmental or sectional meetings is to review the clinical work of that particular unit. While the staff membership may be the same, the clinical case content is not and can hardly be pooled or exchanged.

Several local medical societies have developed schemes for coordinating individual hospital staff meetings with the medical society meeting. This extends the time of the end to end meetings, but reduces the number of occasions. For example, if the hospital staff members were to meet an hour or two early before the regular monthly medical society meeting, they could review the work done in one hospital one time and the other the next. The place is not so important as that the attention be exclusively on the given hospital's clinical work.

Q. If over age 65 patients constitute a large part of total deaths, with the attending difficulty in getting permission for autopsy, will the requirement of 20-25 per cent autopsy rate still prevail?

A. As the standards are presently written, the answer is yes: 20 per cent in nonteaching, 25 per cent in teaching hospitals. However, the main intent is to enhance continuing education of the medical staff. Autopsies in all or most of the deaths representing interesting cases, unsolved diagnostic problems and the like are more important than 20 per cent of all hospital deaths, if the 20 per cent consists of routine and similar cases. Also, the doing of an autopsy is only the vehicle. More significant is the actual discussion

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This question-and-answer page was developed by the Ohio State Medical Association in collaboration with the Joint Commission on Accreditation of Hospitals, John D. Porterfield, III, M.D., Director. Permission to reprint was granted by the Ohio medical society journal.

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7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

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between the clinician and the pathologist about the clinical diagnoses and pathological findings involved. This standard is presently under serious review to see whether the objective can be better achieved by revision. Suggestions?

Q. With the availability of automated typewriters, will it be permissible for staff physicians — surgeons and radiologists, for example, to dictate a normal or standardized report in the case of a normal or routine procedure?

A. Yes, some hospitals now provide some form of automatic typewriter or even computer, and the Joint Commission does not object to their use as a form of dictation shorthand. It is essential only that the report be verified as correct and applicable by the author — the surgeon or radiologist, by his signature. There is concern, however, that this short cut not take the place of cortical activity by the physician involved. Check-off lists for history-taking and physical-examination recording often demonstrate this mouse-trap, where the hurried writer checks a box without conscious thought of what the record then says. It is disconcerting to see the entry on a chart: "Blood Pressure — Yes." Comforting, but not informative.

Q. Why has the Joint Commission not seen fit to explore or establish state-level representation?

A. If by this is meant representation on the Board of Commissioners, concerned interests are represented by seven commissioners named by the American Medical Association, seven by the American Hospital Association, three by the American College of Surgeons, three by the American College of Physicians (and now one by the American Association of Homes for the Aging and one by the American Nursing Home Association since extended care facilities are offered accreditation services). Quality of care does not vary from state to state and the volume of work in any one state usually does not warrant a related state-level representative group. Have I missed the point?

Q. Does the Commission have a concern about the increasing responsibility and dependence being placed on the licensed practical nurse?

A. The Joint Commission recognizes the substantial contribution to nursing personnel resources made by the licensed practical nurse. It recognizes, however, that she must be utilized within the limits of her license and the nursing services must be under the supervision of registered professional nurses. JCAH standards still call for constant (24 hours, 7 days) coverage of the nursing program by RN's and some hospitals have lost accreditation through failure or inability to provide this.

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IN MEMORIAM

I. M. Altshuler, M.D., Southfield

Ira M. Altshuler, M.D., Southfield psychiatrist, died March 17 at the age of 74. Doctor Altshuler was a member of the Southfield School Board from 1960 through 1964 and was active in other civic activities.

Doctor Altshuler was born in Russia and received his medical education at the University of Berne, Switzerland, graduating in 1917. He came to Detroit in 1920, and in 1927–28 he did postgraduate work at Harvard.

He was affiliated with the Wayne County General Hospital, Eloise; Glen Eden Hospital, Warren; Ardmore Acres, Farmington; and St. Clair Hospital, where he had served as chief of staff.

He was a Life Member of the Michigan Psychiatric Association, the Michigan Society of Neurology and Psychiatry, and MSMS. He was a member of the American Geriatric Society.

Doctor Altshuler, whose hobbies included composing music, was instrumental in the use of music in the treatment of psychiatric patients. He was director of the Group-Music Therapy Department at Wayne County General Hospital and an Honorary Member of the National Association for Music Therapists.

R. G. Axelrod, M.D., Royal Oak

Robert G. Axelrod, M.D., Royal Oak, died March 12. He was 45.

Doctor Axelrod was graduated from the Wayne State University School of Medicine in 1946 and interned at Wayne County General Hospital. He served as a captain in the U.S. Army Medical Corps from 1948 to 1950.

With his wife, Mildred Axelrod, M.D., and family, he did medical work in Afghanistan from January 1963 to January 1964. In June 1967 he went to Israel and travelled through the country treating the wounded.

Doctor Axelrod was a Fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine. He played French horn in the Jewish Center Symphony.

G. L. Brody, M.D., Ann Arbor

Gerald L. Brody, M.D., University of Michigan Medical School professor of pathology, died March 31. He was 42.

Doctor Brody attended Oberlin College, Oberlin, Ohio, and received the M.D. degree from Western Reserve University Medical School in 1949. He served in the medical branch of the U.S. Army for two years. He was affiliated with the University of Michigan Medical Center in Ann Arbor.

His hobbies included orinthology, photography, and fly-tying.

Doctor Brody was a member of the International Academy of Pathology and Phi Delta Epsilon fraternity.

J. T. Ferguson, M.D., Traverse City

John T. Ferguson, M.D., director of the geriatrics program at the Traverse City State Hospital, died March 1. He was 59.

Doctor Ferguson received his M.D. degree from the Indiana University medical school in 1948. After three years of general practice in Hamlet, Indiana, he was a resident at Logansport State Hospital, Logansport, Indiana.

He joined the staff of the Traverse City State Hospital in 1955 and participated in early research into the use of tranquilizers and other drugs in the treatment of the mentally ill. He published several articles in medical journals, and a book entitled "A Man against Insanity" was based on his life.

He was a Fellow of the American Geriatric Society and a member of the American Psychiatric Association, the American Association for the Advancement of Science, and Phi Chi fraternity.

Howard Havers, M.D., Detroit

Howard Havers, M.D., retired Detroit physician, died March 3 at the age of 77.

Doctor Havers, a Life Member of MSMS, had practiced in Detroit from the time of his graduation from the Detroit College of Medicine and Surgery in 1913. His internship was served at Grace Hospital and he remained a member of staff there, specializing in internal medicine.

For many years he served as a medical examiner for the draft board.

He was born in Sarnia, Ontario, and attended the Sarnia Collegiate Institute before he enrolled in the Detroit College of Medicine.

His medical fraternity was Phi Beta Pi.

C. L. Hess, M.D., Bay City

Charles L. Hess, M.D., retired Bay City internist, died February 25 at the age of 80.

He had practiced in Bay City for 31 years before his retirement in 1950. He served on the Bay City Board of Health and the Michigan Department of Health.

Doctor Hess held B.S. and M.S. degrees from the University of Chicago and received his M.D. degree from the Northwestern University medical school in 1914. His internship was done at Cook County Hospital and residency at the Mayo Foundation. During World War I he served with the Chemical Warfare Service and he was chairman of the medical advisory committee of the Bay City Selective Service Board during World War II.

He was a Life Member of the American Society of Clinical Pathology, the American College of Physicians and the American Heart Association, and a member of the American Diabetic Association, the Aero Medical Association, the American Physiological Society and Sigma Xi fraternity.

A past president of the Bay County Medical Society, he was the author of articles in numerous scientific journals.

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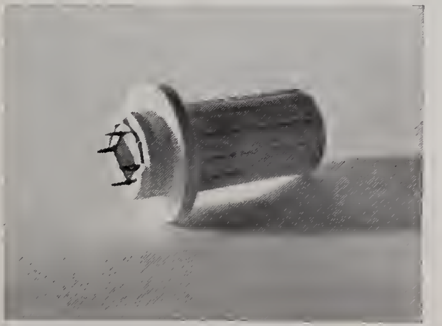

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W. B. Hubbard, M.D., Flint

William B. Hubbard, M.D., Flint othphalmologist, died February 26 near Sebring, Florida. He was 69.

Doctor Hubbard was graduated from the University of Virginia medical school in 1923 and had resided in Flint since 1930. He was affiliated with Hurley, St. Joseph and McLaren hospitals in Flint and was on the courtesy staff of Ford Hospital, Detroit.

He served in World War I and was a USAF Major in World War II. For 20 years he served as an examiner for the Civil Aeronautics Authority.

Doctor Hubbard was the author of a number of research and scientific papers. He was a Life Member of the American College of Surgeons, a member of the American Academy of Ophthalmology and Otolaryngology and a past president of the Saginaw Valley Academy of Ophthalmology and Otolaryngology and the Detroit Academy of Ophthalmology.

Memorial donations were made to the AMA-ERF.

I. S. Lilly, M.D., Stanton

Isaac S. Lilly, M.D., a Montcalm County physician for 52 years and former North American trapshooting champion, died March 5. He was 85.

Doctor Lilly was graduated from the University of Louisville medical school in 1909 and practiced in Lester, West Virginia, until 1915 when he moved to Michigan. After two years in McBride,

Continued on 702

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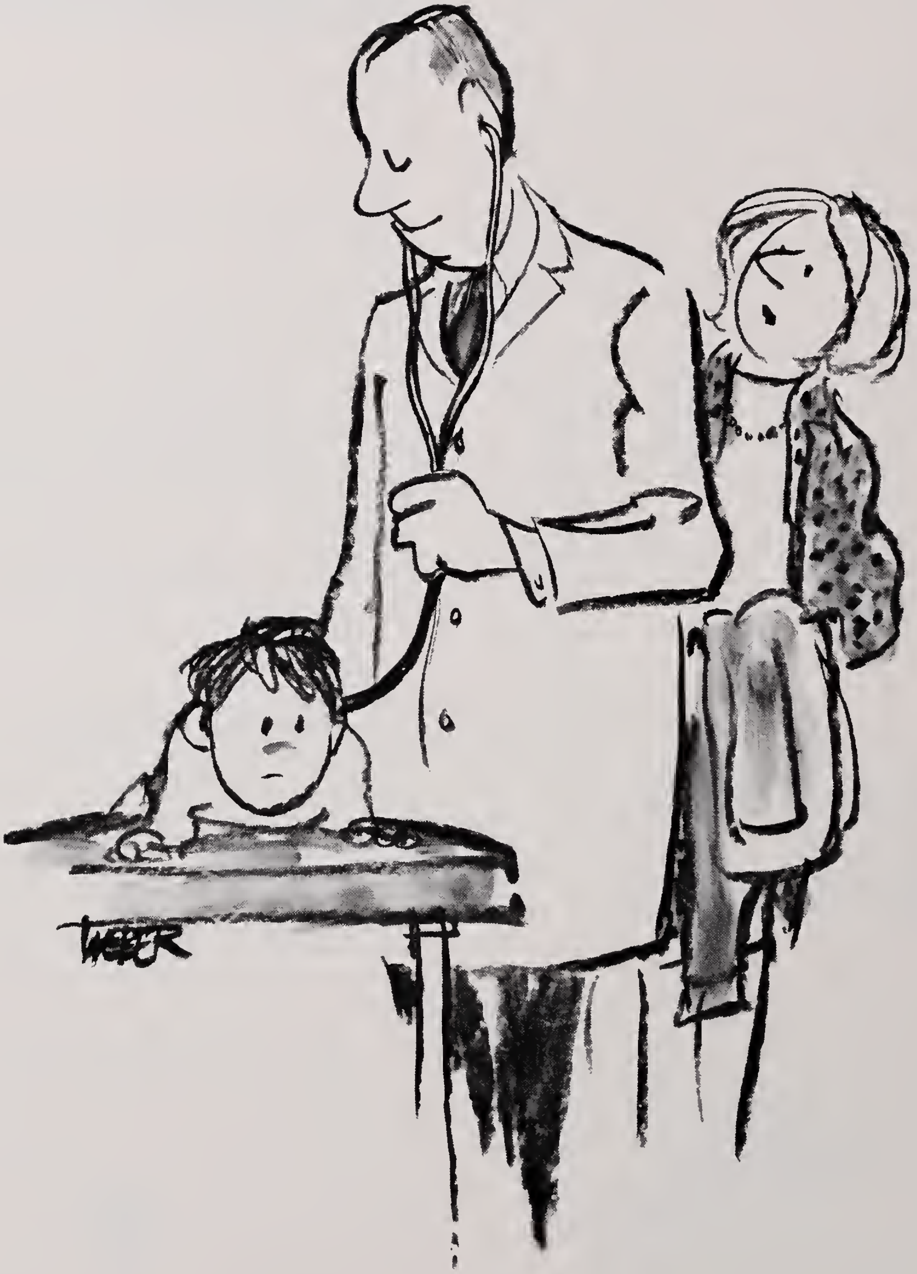

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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he established his practice in Stanton which he continued throughout his life.

He was mayor of Stanton for about 15 years and served as County Coroner for 35 years and health officer for 47 years. A Life Member of the American Trapshooting Association, Doctor Lilly and his son twice won the national father-and-son clay target championships.

He was a Life Member of MSMS and was once president of the Ionia-Montcalm Medical Society.

J. R. McBride, M.D., Lapeer

John R. McBride, M.D., a former president of the Lapeer County Medical Society, died March 28. He was 64.

Doctor McBride was graduated from the University of Iowa Medical School in 1929 and came to Michigan in 1930. He was affiliated with the Lapeer County General Hospital in Lapeer and the McLaren General Hospital in Flint. In addition to serving as president and vice-president he also served as secretary of the Lapeer County Medical Society.

From 1942 to 1945 he served in the medical military service. He was a member of the American Legion and Phi Beta Pi fraternity.

H. C. Wass, M.D., Port Huron

Henry C. Wass, M.D., Port Huron general practitioner, died March 23 at the age of 71. Doctor Wass was a former president of the St. Clair County Medical Society.

Doctor Wass was graduated from the University of Michigan Medical School in 1927. He held a B.S. degree from Michigan State University.

In 1927 and 1928 he served in the medical branch of the U.S. Navy.

He was affiliated with Mercy Hospital in Port Huron and St. Clair Hospital.

R. J. St. Louis, M.D., Detroit

Rene J. St. Louis, M.D., Detroit general practitioner, died March 11 at the age of 80.

He was a city councilman in River Rouge from 1931-1933, was honorary fire chief of the River Rouge fire department, and served as health officer of the River Rouge Health Department.

Doctor St. Louis, who was born in Sandwich, Ontario, received his M.D. degree from the Detroit College of Medicine and Surgery in 1910. He served his internship at Harper Hospital, then entered practice in Midland. After serving in the medical military service during World War I, he began practice in River Rouge.

He was affiliated with Delray Hospital and Wyandotte General Hospital.

Doctor St. Louis was a Life Member of MSMS and a member of Nu Sigma Nu medical fraternity.

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- Medico-Legal counsel.
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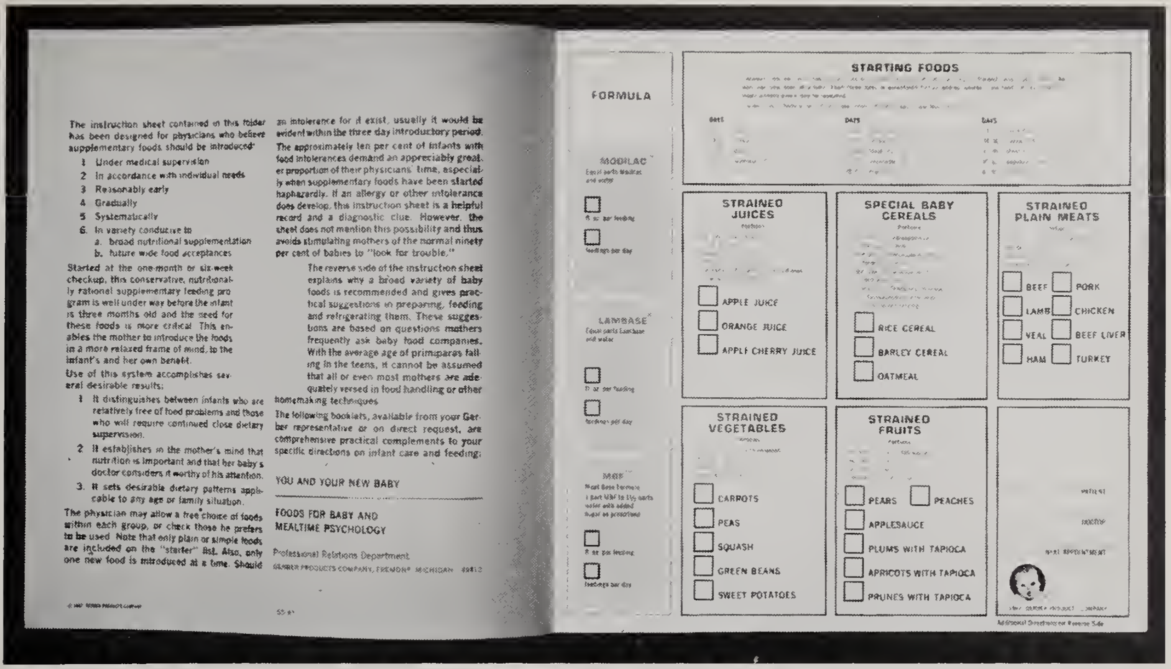

The instruction sheet contained in this folder has been designed for physicians who believe supplementary foods should be introduced:

1. Under medical supervision
2. In accordance with individual needs
3. Reasonably early
4. Gradually
5. Systematically
6. In variety conducive to
   - a. broad nutritional supplementation
   - b. future wide food acceptances

Started at the one-month or six-week checkup, this conservative, nutritionally rational supplementary feeding program is well under way before the infant is three months old and the need for these foods is more critical. This enables the mother to introduce the foods in a more relaxed frame of mind, to the infant's and her own benefit.

Use of this system accomplishes several desirable results:

1. It distinguishes between infants who are relatively free of food problems and those who will require continued close dietary supervision.
2. It establishes in the mother's mind that nutrition is important and that her baby's doctor considers it worthy of his attention.
3. It sets desirable dietary patterns applicable to any age or family situation.

The physician may allow a free choice of foods within each group, or check those he prefers to be used. Note that only plain or simple foods are included on the "starter" list. Also, only one new food is introduced at a time. Should an intolerance for it exist, usually it would be evident within the three day introductory period.

The approximately ten per cent of infants with food intolerances demand an appreciably greater proportion of their physicians' time, especially when supplementary foods have been started haphazardly. If an allergy or other intolerance does develop, this instruction sheet is a helpful record and a diagnostic clue. However, the sheet does not mention this possibility and thus avoids stimulating mothers of the normal ninety per cent of babies to "look for trouble."

The reverse side of the instruction sheet explains why a broad variety of baby foods is recommended and gives practical suggestions in preparing, feeding and refrigerating them. These suggestions are based on questions mothers frequently ask baby food companies. With the average age of primiparas falling in the teens, it cannot be assumed that all or even most mothers are adequately versed in food handling or other homemaking techniques.

The following booklets, available from your Gerber representative or on direct request, are comprehensive practical complements to your specific directions on infant care and feeding:

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FOODS FOR BABY AND
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PATIENT

DOCTOR

NEXT APPOINTMENT

Additional Directions on Reverse Side

Checklist for Planned "Starting" Nutrition

A new Gerber service for physicians
The starting foods instruction sheet was designed to help assure your professional supervision and control of the introduction of supplementary infant foods. An adequate variety of *plain* foods is listed to provide latitude in prescribing for individual requirements. It is a timesaver for the selection of foods and their sequential introduction. Your rationale is explained to the mother.

Use it as a checklist
Your √ designates the use of one plain food at a time. Portions are listed and increased gradually until the food is well accepted. Should an intolerance develop, it would be evidenced in the "diary" of food experience. Diagnostic clues would be pinpointed. An alternate food could be selected.

A built-in plan of rotation
This schedule, starting with plain strained juices, provides for adding single foods in succession—one-grain cereals, strained plain meats, strained plain vegetables, strained fruits. Initiated at the one-month or six-week checkup, the system is programmed for up to forty-five days. By then, the infant will be introduced to a variety of at least fifteen foods which you have selected from the list of twenty-five.

Start as early as you wish
The system can be started at the initial checkup. Space is provided for you to indicate your choice of formula. Simply enter the amount per feeding and the number of feedings per day in the appropriate square. For normal infants, you may select the Gerber Baby Formula . . . Modilac,™ premodified milk with a near-ideal distribution of calories that has demonstrated superior growth and development.* For newborns where there is a family history of allergy or other reason to avoid milk, MBF™ (Meat Base Formula) or Lambase® can be checked.

Feeding facts your mothers should know
No starter food system is complete or workable without the understanding and cooperation of the mother. We provide for that, too. On the reverse side of the "checking" sheet, mothers are informed why the infant's diet should be based on the four basic food groups; why she should take time to teach her baby to adjust to new foods; why it is important to observe simple precautions such as transferring food from the original container if some is to be refrigerated until another feeding.

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Your requests gave us the idea for this system. All we did was make it as flexible and easy-to-use as possible. Your Gerber Medical Service Representative will be pleased to show it to you. We invite you to inspect it closely ...and start using it in your practice.

* Lowe, Charles U., M. D. et al., J. Pediatrics 64: 666-682, 1964.

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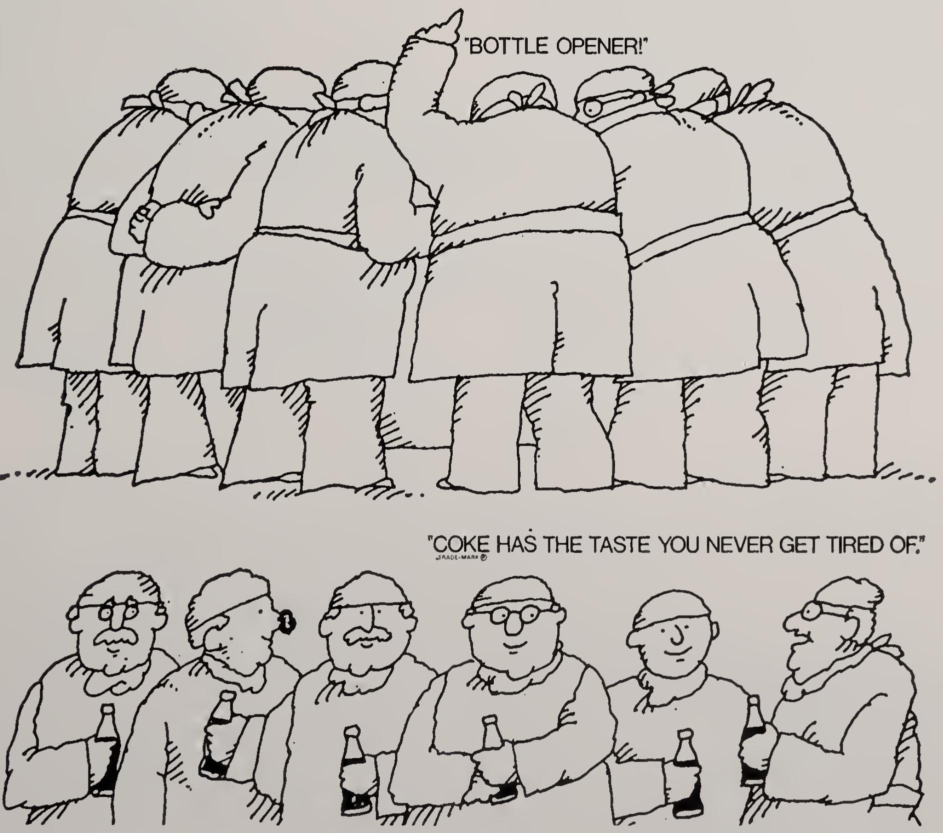
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MSMS Members In the News . . .

Michigan State Medical Society

Marjorie Peebles-Meyers, M.D., Detroit,
has been named one of the "Ten Top Working Women" in Detroit. Each Spring the community salutes ten women for outstanding professional contributions and community service. Doctor Meyers is a Delegate to the MSMS House of Delegates and an Alternate Delegate to the AMA House of Delegates.

John Stirling Meyer, M.D., Birmingham,
will administer a grant of $75,600 from the U.S. Public Health Service to the Wayne State University School of Medicine for continuing the neurology training program. He is professor and chairman of neurology at WSU.

Karl S. Klicka, M.D., Wayne,
Executive Director of the People's Community Hospital Authority, was elected secretary of the new Michigan Association of Hospital Authorities.

Joseph R. Montante, M.D., Orchard Lake,
has been named Republican party organization director in the 19th Congressional District. He is a precinct captain in West Bloomfield Township Republican Party.

Allen B. Moore, M.D., Essexville,
has been appointed by Governor Romney to the eight-member Saginaw Valley College Board of Control. Doctor Moore also was head of the Easter Seal campaign conducted by the Bay County Society for Crippled Children and Adults.

Lionel F. Swan, M.D., Detroit,
president of the National Medical Association, met recently with President Johnson and presidential assistants to explain the role of the newly formed NMA foundation. The foundation's over-all program, aimed toward comprehensive care of the urban poor, includes a nationwide program of recruitment to health professions which offers financial support to deserving young people. The program is being conducted by NMA with the cooperation of the departments of Health, Education and Welfare, and Housing and Urban Development.

Otto K. Engelke, M.D., Ann Arbor,
has been appointed to the AMA Council on Environmental Health and also to the Ad Hoc Committee to Study the Modus Operandi of the Scientific Section.

Geoffrey L. Brinkman, M.D., Detroit,
will direct studies of the aging process that occurs in lungs under a $16,600 grant by tht Michigan Tuberculosis and Respiratory Disease Association to the Department of Pathology at Harper Hospital, Detroit.

William H. Knisely, Ph.D., East Lansing,
has been appointed by the Surgeon-General to the National Advisory Council on Education for Health Professions of the U.S. Public Health Service.

James C. Breneman, M.D., Galesburg,
was presented a 15-year service pin by the local draft board for work as a medical adviser. Also cited was Edmund Talanda, M.D., Kalamazoo, for five years of service to the board.

Albert D. Ruedemann, M.D., Detroit,
professor and chairman of ophthalmology in the Kresge Eye Institute, WSU, will direct the new Children's Fund, established through a $16,059 gift from the estate of Edna F. Selberg. The money will be used to purchase equipment and provide free eye services to children from the Midwest and parts of Canada.

James T. Howell, M.D., Detroit,
executive director of Henry Ford Hospital, has been elected to a three-year term as a hospital representative on the Michigan Blue Cross Board of Trustees.

John Kitchel, M.D., Grand Haven,
representing the Michigan United Conservation Clubs, was chairman of an afternoon session at the conference on "Informed Forces for Environmental Quality" held at Green Bay.

V. K. Volk, M.D., Saginaw,
was honored for more than 30 years as Saginaw County health commissioner in an informal ceremony at which his portrait and a commemorative plaque were placed in the County Health Center. He retired as health officer last year but continues as medical superintendent of Saginaw County Hospital.

MICHIGAN MEDICINE

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This woodcut of muscles, attributed to the workshop of Titian (Italian, 1477-1576) will be one of the more than 130 original works of art in the "Ars Medica" exhibition at The Detroit Institute of Arts during the 1968 MSMS Annual Session in Detroit in September. See page 739.

MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 11
JUNE 1968

AMONG THE IMPORTANT ARTICLES

The New Physician
"Ars Medica" Exhibition
MSMS Thrust in National, International Affairs
List of Component Officers
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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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MICHIGAN MEDICINE

JUNE, 1968 • VOLUME 67 • NUMBER 11

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ABOUT THE COVER:

The woodcut on the cover is one of the original works of art that will comprise the "Ars Medica" exhibition at the Detroit Institute of Arts during the 1968 MSMS Annual Session. See the article on Page 739.

The sketch on Page 732 with the Llinas article was drawn by Craig Dennis, a senior at Lansing Eastern High School who plans to attend college to study medical illustrating.

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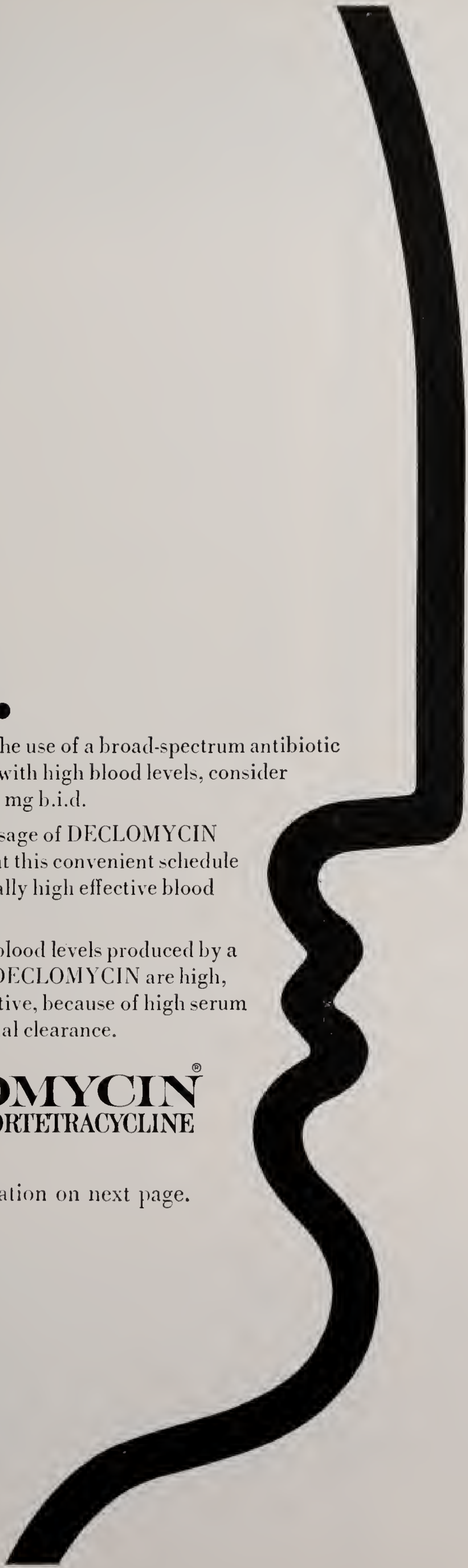

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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg every 6 hours for a minimum of 4 doses or 300 mg every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg every 6 hours or 300 mg every 12 hours until a cure is effected.

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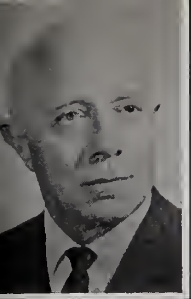

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

About Our Image . . .

How important is image?

Image is important it seems to me if doctors are really concerned about the opinions of their patients, about the comments of editors and educators, and about the attitudes voiced by legislators and other professionals.

Image is important as doctors perform well, obtain respect, and achieve economic security and self fulfillment.

* * *

You might ask, "what do you mean by image?"

There is a simple definition: Image is a mental-emotional picture held by our many publics in health, government, education, communications, etc.

These impressions of doctors are gained every day, every hour in so many ways.

* * *

Can the image be changed?

Certainly. And the impressions are changed almost every hour for the better . . . or the worse.

May I be so bold as to write about some of the factors that effect your image — so you might be able to evaluate your weak points and build upon your strengths?

Our image, I believe, relates to . . .

A man's knowledge, his professional abilities, his management skills, his ability to budget his time;

A person's appearance, voice, handshake, eyes, smile;

A doctor's civic contributions, business practices, family relationships;

A physician's patience, tact, manners, cordiality;

A person's dedication to continuing education, to ethics, to his nation.

These comments have been aimed at every physician as an individual. I firmly believe that each of us can improve our personal image if we continue to improve our professional performance, if we fulfill our role as a citizen, and if we respect the members of our family.

* * *

As a former chairman of the MSMS Publication Committee, I would like personally to thank George H. Lowrey, M.D., for his outstanding service as Scientific Editor of Michigan Medicine since April, 1966. And at the same time, I wish John W. Moses, M.D., the new Scientific Editor, the best as he succeeds Doctor Lowrey. MSMS indeed has been fortunate to have such men in recent years as Wilfred Haughey, M.D., C. J. Tupper, M.D., George H. Lowrey, M.D., and now John W. Moses, M.D., as dedicated editors to provide the members with the best of timely, vital scientific articles.

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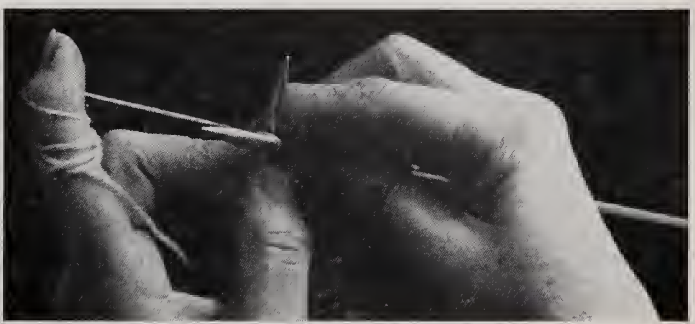

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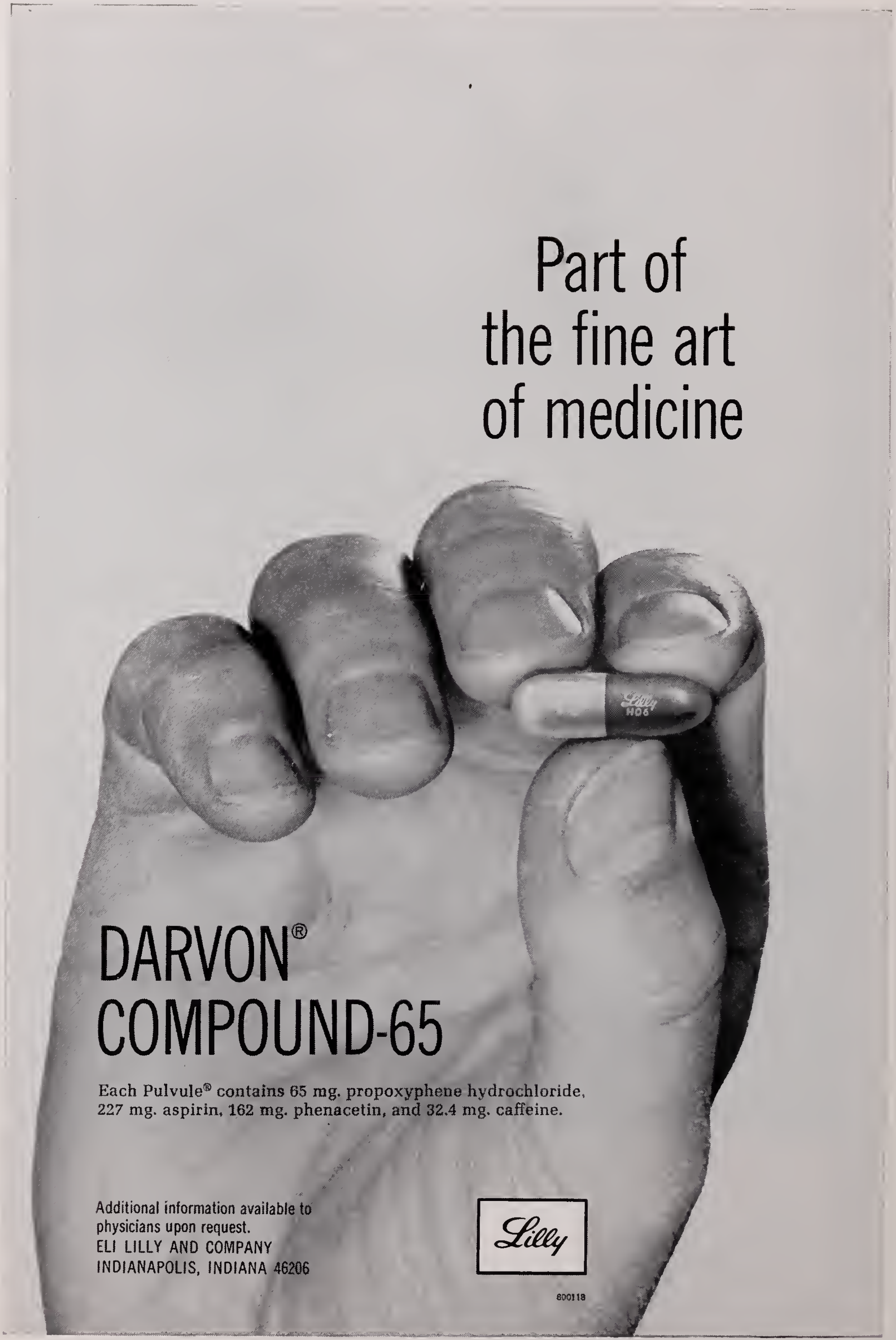

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Obstructions and Pitfalls In Implementing the "New Physician"

BY RICHARD M. MAGRAW, M.D.
WASHINGTON, D.C.

The word "pitfall" implies a hidden and not easily recognized danger or difficulty when, in fact, there are plenty of obvious and recognizable obstructions which block our way and impede our progress toward "the new physician." Moreover the term "pitfall" suggests an unforeseen interruption in a program already underway, implying that we are farther along in this effort than we are.

In this project we are still struggling with obvious blocks to attain the goal. To draw an analogy from a childrens' Christmas story, "The Little Engine That Could," we are yet on the uphill track of "I think I can, I think I can" rather than having attained the downhill version of "I thought I could, I thought I could."

This distinction is made to emphasize what has been and continues to be the chief block to the implementation of the new physician concept, namely, our confusion as a profession about realities of our time. In part, because we have been too busy practicing and providing care, we have not understood the enormous changes in our time, and we have consistently underestimated the complexity of the adaptations which are demanded of us. We are indeed "walking backward into the future."

For example, there has been a general assumption that the task of implementing the new physician could be accomplished simply by persuading the medical schools and teaching hospitals to develop an appropriate instructional program for family practices. However, to implement the new physician, not only must medical education (undergraduate and graduate) be restructured, but the division of labor within the traditional medical profession must be revised; the relationship and functions of the elements of the larger medical care apparatus (i.e., clinics, hospitals, and related health personnel) must be modified; arrangements for payment for medical services will need to be significantly altered; and public understanding and acceptance must be won. In each of these areas there are obstructions and pitfalls.

I. Blocks to the Development of Residency Programs within Medical Education

A. Blocks within the medical school and its associated hospitals and clinics.

Although most schools are currently modifying some of the undergraduate curricula, we will not here consider undergraduate aspects of education for this new role. The modification of undergraduate education is not absolutely essential to implementing the new physician concept.

Since most physicians have heard much about the pitfalls and obstructions of implementing this program within the medical schools, I will list them here only in an abbreviated way.

WHEN FACULTIES COME to consider establishing programs for the "new physician" in medical schools, they find they have undertaken a very large order for these reasons:

(1) In general, medical school faculty members are not knowledgeable about the medical care apparatus per se and are unaccustomed to assessing the characteristics of the practicing profession in terms of the medical needs of society. They are often so far removed from the communities' medical care needs as to be unable to make judgments regarding the training required for primary care in today's world.

(2) Medical schools, hospitals, or clinics are usually referral or charity institutions or both. As such, they have neither an established role in, nor a tradition of providing first-line comprehensive medical care. And, as they attempt to develop new and more suitable facilities for training, they expect objections from the practicing profession for intruding into primary care. Thus far, their anticipations have proven correct.

(3) There is a new division of labor implicit in the concept of the new primary physician which runs counter to the existing departmental structure as well as the associated professional

models which are strongly entrenched in medical school usages, concepts, and politics.

(4) The campaign for the new physician developed in relation to implied or expressed threats to the research enterprise, which is the preponderant force in today's medical school.

(5) The traditional medical school has evolved into a medical research and graduate training center. The medical education part of this enterprise (as opposed to the research portion) is not able to undertake a new training program without major additional financial support.

(6) It is very nearly impossible for any one school by itself to undertake the required major revision of either graduate or undergraduate training. Hence, a cooperative effort is necessary. Further, it is difficult for medical educators, even as a group, to undertake to produce a "new physician," (including a new role) unless the institutions and arrangements of medicine and society are also changing to provide a place for him.

In addition to lacking the incentive to implement this program, academic medicine has a conservatism of its own, which, in this matter, appears to be about as intransigent as that of the practicing profession.

B. Obstructions within the teaching hospitals (public or private) not affiliated with medical schools.

At the present time some of the most promising starts toward implementing the new physician are occurring in these hospitals, particularly the private ones.

City and county hospitals (charity hospitals) are having difficulty with the concept. Their major problem appears to be that the medical care provided the patients by such hospital staffs has been far from comprehensive. Regardless of the quality of in-hospital care given, the overall care usually has been fragmentary because of the hospital ward and categorical orientation situations. Outpatient care has been poor in quality, and concepts of community health needs have been limited to calculating bed capacity and comparing the technological sophistication of the particular hospital with similar institutions.

Private hospitals are in a stronger position, for implementing the training for the new position, for doctors on their staffs provide primary care, paradioxically, because their work is oriented much more toward their offices and the community than to the institution. However, the private hospital, to a greater or lesser extent, has a recognized position of trusteeship for the medical resources of the community, thanks to Hill-Burton regional hospital planning, etc.

THE MOST ESSENTIAL new elements for education of the personal physician are the demonstration of: (1) the managerial responsibility of the individual personal physician, and (2) the linkage between such responsibility and the cooperative enterprises of medicine as in the hospital and its medical staff. At present the private hospital-medical staff combination offers the only existing demonstration of this, although the models are far from being adequate for instruction of tomorrow's physician.

II. Blocks within the Practicing Profession

The obstructions within the practicing profession are not fully separable from those within the medical schools and teaching hospitals. They all derive from a tendency among some doctors to see this as a circumscribed issue involving, fundamentally, the general practitioners. This is opposed to seeing the issue as a general restructuring and rationalization of medical care or as understanding the need for such restructuring.

Now the chief overt opposition to this concept comes from some groups of internists and pediatricians and, to a considerably lesser extent, from obstetricians and general surgeons. Not surprisingly, the publications of the Millis and Willard reports, as well as the other reports and publications which have supported the concept, have resulted in a crystallization of opposition to the "new primary physician" concept within the groups who feel threatened.

PEDIATRICIANS AND INTERNISTS have objected to this concept because they sensed in it a contrived revival of the surgically oriented and, in their view, inadequately trained general practitioner and have perhaps felt it an implied criticism or undermining of their role.

In general they have perceived this as a threat, rather than an opportunity for evaluation of their own role. Editorials in some journals this past year, while acknowledging that there are now different kinds of internists and pediatricians which may require different training, tend to see these as variations within the disciplines of pediatrics and internal medicine rather than as a small-scale replica of the generalist-specialist problem.

As yet internists and pediatricians seem little aware that in the long run not only the interests of the American public, but the self-interest of all personal or family physicians, regardless of professional label or type of training, will be best served by defining this function and improving it by training. At the bottom of this problem are two cherished misconceptions: First, internists and pediatricians are retaining an outdated concept of their role and training as general specialists. It is becoming clear to all that these general specialists have already been divided by their work into two broad groups—those that preponderantly provide primary care and those that serve as consultants. It is, further, becoming clear that the evolving organization of medical care demands further polarization of these roles and a formalization of them.

Second—another cherished idea is that the internist or pediatrician should be trained for the consultant aspect of his work, but he needs no special training for primary care. This idea is apparent in the insistence that all internists are internists and all pediatricians are pediatricians; that is, they should all have a common training and pass a common board examination demonstrating a consultant's level of competence.

A CYNIC MIGHT remark that this incidentally assures their maintaining amateur standing in the field of primary care.

Romano, some time ago, stated that the scientist's first loyalty was to his clinical material. The "clinical material" of the internist trained on the wards of a teaching hospital is very different from that involved in the patient care he will provide as a primary physician. He has not yet resolved the issue as to what "clinical material" he will give his loyalty.

Not the least of the problems of implementing of the new physician concept within the medical profession itself is the political power and vested interest of existing specialty boards. These boards have performed valuable functions for society by elevating professional standards. However, their orientation in medical care has always been limited to the specialty. They have eschewed any assessment of overall medical care or unmet community needs. Each specialty board has concerned itself with improved professional functions in the specialty, usually by making progressively more demanding measurements of expertise.

Taken together these forces within the medical profession seriously impede development of educational programs and recruitment for the new professional model.

III. Blocks in the larger apparatus of medical care and health; e.g., clinics, the hospitals, and related health professions

As noted earlier some of the most promising beginnings in graduate training programs for the new physician are being made in private hospi-

AUTHOR

Doctor Magraw is the new director for extramural relations of the Public Health Service's bureau of health services in Washington. He formerly was professor of psychiatry and neurology, and of internal medicine at the University of Minnesota Medical School.

tals. There are, however, some important pitfalls involved.

IN WHAT MIGHT BE described as the "hospital view of medical care," the hospital rather than the primary physician is seen as the center of medical care. This is apparent in the recommendations made by various governmental and quasi-public commissions concerned with meeting the medical needs of society. They recommend that hospitals* should serve as the center of care for all patients and that they should specifically manage the personal medical care and provide referral services for all persons who do not have personal physicians.

Owing to the seriousness of the need, the shortage of physicians, and the lack of either a consensus in, or a forward looking alternative from, the medical profession, this hospital-center idea has considerable appeal. This idea is also widespread among hospital administrators and planners in medical care. It is one of the obstructions of implementing the new physician since it implicitly denies the need for his function. It suggests that we do not really need any professionally trained person to carry out this function, at least for the persons who have now been given medical purchasing power but do not have personal doctors. It becomes all the more important when we understand the weight which this view is likely to receive politically and recognize that hospitals heretofore have characteristically looked inward and oriented themselves to a concept of care of episodic disease rather than comprehensive continuing care. Thus, in many ways the hospital portion of medical care is conceptually the natural antitheses to the part of comprehensive personal care which is the basic function of the new physician.

IV. Blocks in medical economics and the payment for medical care

In my view the most important obstructions to implementing the new physician concept are in the economics of medical care and specifically in remuneration for services. Although the history of this is long and complicated, the problem itself can be simply stated. Comprehensive personal medical care has seldom been explicitly recompensed. In general it's been a "loss leader" or a "give away item" at the medical market place. Schedules of benefits of third parties are endlessly detailed and explicit in regard to technical procedures. Only vaguely and implicitly, if at all, however, do these schedules acknowledge that there is a wider element of skill and time required for comprehensive care of the patient than for obvious procedures of medicine. There is probably nothing which could be done in medical training or in the organization of medical care which would as quickly implement the concept of the new physician and correspondingly rationalize our entire system of medical care as developing a realistic remuneration for the managerial and integrating services of the primary physician. It is hard to do this on a fee basis. How can he be paid for studying the consultation report or for all the other things involved in integrating a patient's care or preventive maintenance?

IN MY OPINION there is no more practical way of doing this than establishing, in addition to existing fees for service, some modest "retainer

AMA Ad Hoc Report On "New Physician" Available from MSMS

Thoughts about "the new physician" were advanced in the Report of the AMA Ad Hoc Committee on "Education for Family Practice," published by the AMA. William R. Willard, M.D., vice-president and dean of the University of Kentucky Medical School and chairman of the Ad Hoc Committee, spoke at the 1967 MSMS Annual Session and was followed by Doctor Magraw. The Report was studied in detail this past year by the MSMS Education Liaison Committee. Interested MSMS members may obtain a copy of the Ad Hoc Committee report by writing to MSMS, 120 West Saginaw, East Lansing 48823.

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*In order to avoid false issues it is important to understand that many people use the term "hospital" here in a broadly encompassing way meaning the medical care apparatus of society with the physician at its core. "Medical center" or "health center" would probably be a preferable term, but the idea of hospital has both high visibility and loyal constituency.

fee" or "availability fee" paid annually by each patient (or on his behalf by a third party carrier) to the doctor who assumes ongoing medical responsibility for him.

Devising some way of realistically paying for comprehensive personal care would probably brush away all existing obstacles in the path of the implementation of the primary physician. It would define, in the public mind, the professional role which has become all but invisible under current medical care and medical pay arrangements. It would, similarly, define in professional thinking the function which some doctors still regard as an attempt to give to "airy nothing a local habitation and a name." Payment gives it substance. In this regard it's well to recall the bitter struggles which occurred within the last few years over the issue of surgical privileges in hospitals for general practitioners. These struggles were not wholly or even primarily economic. They grew out of the general practitioner's difficulty in defining a professional role for himself or maintaining a professional identity in other terms than surgical expertise. Surgery was what he got paid for, and it was correspondingly in surgical terms that he defined his function and measured his professional identity.

The personal physician's situation regarding pay for comprehensive personal care is analagous to that of the free lunch in the days of the saloon when the lunch was supplied to help sell the beer which made the profit. By analogy, the beer is the technical part of medicine that third parties pay for. When the beer was separated from free lunch (that is the surgery was separated from the comprehensive personal care), not only was the doctor's livelihood affected, his professional identity was diluted and threatened.

V. Blocks in public understanding and acceptance

Perhaps the biggest block to public understanding and acceptance of the new physician is a psychological one wherein the individual members of society, particularly at a time when they are not sick or active patients, maintain the fiction that illness or disease is an alien external thing which can be dealt with, removed, or cast off without involving them personally.

The potential dependence on another person, the lessened interpersonal distance, and the trust required all are a little frightening and will be avoided like "flouridation" unless their usefulness is understood.

At present the implementation of the primary physician may still be largely in professional hands, but soon and in any event, ultimately this will be a social or political decision. This professional role concerns all doctors, not only general practitioners, internists, and pediatricians, as it will bring to pass a long overdue and adaptive division of labor.

SUCCESSFUL IMPLEMENTATION of this new physician is of importance to all Americans as it will provide integration at the interface between the individual patient and an increasingly complex technology and apparatus of medicine.

Failure to bring this about is almost certain to cost us part of what we value the most, the human content of our lives.

Clinical Response to Iron-Polysaccharide Complex In Geriatric Patients With Iron-Deficiency Anemia

ABSTRACT — The geriatric patient often offers so many problems that iron-deficiency anemia is frequently neither suspected nor investigated. This article indicates that simple therapy with an oral preparation results in a prompt response in most older patients.

BY JACK F. SANDERS, M.D.
ALMA

Physicians have been offered many types of iron preparations, including ferrous sulfate, gluconate, and fumarate. Although they produce the desired hemoglobin responses, these forms of iron have been reported to irritate the gastrointestinal tract.[1,2,4] Adverse effects accompanying the administration of these agents (e.g., nausea, diarrhea, anorexia, constipation, abdominal cramps) are sufficient in some cases to interrupt their use.

When iron in the form of a polysaccharide complex was found to be less toxic to mice than the standard ionized forms, its possible clinical applications were investigated. In this form, the elemental iron is supposedly bound in complex until dissociated by hydrochloric acid in the stomach; it is absorbed in the duodenum and jejunum, where iron absorption is maximal. Children receiving non-ionizable iron have been reported to respond well, with good hemoglobin response time, and no clinically significant adverse affects. In geriatric patients whose chronic diseases may render them less responsive and more sensitive to irritating therapeutics, such a non-toxic form of iron would be desirable.

To further test the acceptability of this water-soluble hematinic,* the present study was conducted in geriatric patients with iron deficiency anemia.

Method and Material

Participants in this study were selected from residents of the Michigan Masonic Home and Hospital, a uniform socio-economic group with a mean age of 84. Of 392 screened with CBC's with peripheral smears and stools for blood, only 20 had iron deficiency anemia requiring treatment (i.e. hemoglobins below 12.0 grams, average 10.7 grams, and hypochromic morphology). They ranged in age from 78 to 95. Diagnostic upper GI and colon examinations were also performed in 80 of the possible candidates. Of these, 3 were found to have colon malignancies and were successfully operated before signs or symptoms had become manifest; they were not included in the study. Carcinoma of the caecum was discovered in 1 patient and successfully operated after the initiation of iron therapy. Eight patients showed trace to + blood in the stool without identifiable source. Multiple chronic diseases which might interfere with the response were present in every patient. Cardiovascular renal diseases complicated the conditions of 16 patients; 4 men had prostatism; 2 women chronic glomerulonephritis.

Patients ate a 1.0 Gram salt diet at special diet tables. The stable living pattern was interrupted in only 1 patient who was removed to another hospital for surgery.

Each patient received polysaccharide iron complex in elixir form, one teaspoonful bid for a total daily dose of 200 milligrams of elemental iron. Nurses administered all medications. Subjective evaluations of the palatability and acceptability of the elixir were offered by the patients.

Prior to therapy, CBC's including reticulocyte counts, hemoglobin and hematocrit values, BUN's, urinalyses, and Diagnex Blue tests were done. Because the time for response to iron therapy in geriatric patients was not known, treatment was continued for 12 weeks and repeated testing was done at 2 week intervals during treatment and at 1 month and 6 months after its termination. One technologist performed all the tests.

Results and Discussion

During the first 28 days hemoglobin values rose in 15 of 19* patients with an average increase of 1.5 grams, and with corresponding hematocrit increases of 2.33 vols.%. The 5 non-responders all had severe cardiovascular renal disease and chronic blood loss in the stool. Only 1 of the responders had blood in the stool. Two of the responders had no free gastric hydrochloric acid and 9 had only a

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*Niferex, oral iron polysaccharide complex marketed by Central Pharmacal, Seymour, Indiana.

*1 of the 20 patients died of unassociated causes too early in this study to be included.

THE AUTHOR

Doctor Sanders is medical director for the Michigan Masonic Home and Hospital at Alma.

trace as indicated by the Diagnex Blue test. Reticulocyte counts showed no apparent relationship to response or lack of it.

Six months after the 12 weeks of administration of iron polysaccharide complex, 4 of the 15 responders had dropped back to their original hemoglobin levels, with no evidence of blood loss. The 4 non-responders were all lower at the end of the study than initially despite the iron intake.

One patient complained that he "just didn't like" the medication. One complained of momentary flushing and another of transistory stomach distress for a few minutes after each dose; the complaint was not serious enough in either to require alternation of therapy. All patients wore dentures; there were no denture stains.

Conclusion

Simple iron deficiency anemia in a geriatric population on a well controlled pablum is less prevalent than commonly supposed, only about 1 in 20. Non-ionizable polysaccharide iron was effective in 15 of 19 such patients, and was well accepted and well tolerated in all 19. An arbitrary dosage of 200 milligrams of elemental iron per day produced clinical responses within the first 28 days of therapy. None of the patients had any significant gastrointestinal irritation or any sign of toxicity. The coexistence of multiple chronic diseases did not interfere with response, with the exception of cardiovascular renal disease with elevated BUN's and chronic blood loss. Total absence of free gastric hydrochloric acid or only trace amounts as indicated by Diagnex Blue testing did not interfere with iron absorption and hemoglobin response.

These preliminary studies warrant further investigation in depth and with controls of this type of iron therapy.

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Early Strategies in the Treatment Of the Anxious Patient

ABSTRACT—Anxiety is a "fear syndrome," expressing a patient's reaction to a life situation which he perceives as dangerous. When the physician gains some insight into the nature of the patient's fear, and communicates this understanding to him, within the framework of a friendly doctor-patient relationship, the condition is apt to improve.

BY JOSE' J. LLINAS, M.D.
LANSING

All of us have lived through times of anxiety and tension. Moments of dreadful anguish, torturing expectations that something terrible is about to happen, and that we are powerless to prevent it, are a universal experience.

Anxiety becomes of concern to the physician, however, only when it is so constant or so severe that it interferes with the patient's enjoyment of life, his relationship to others or his ability to work.

Definition

Anxiety is a disagreeable, unpleasant feeling, which patients describe in a variety of ways, since it has both subjective and objective physiological components. They are "nervous," "apprehensive," "worried," "insecure," "shook-up." They have misgivings about their state of health, and the soundness of their minds. They complain of head pressure, pain in the chest, palpitation, nausea, chills, fever, cold hands, sweating, agitation, restlessness, insomnia. . . .

They are scared, and show the signs and symptoms of fear; though they can't exactly tell what terrifies them.

There is a wide spectrum of clinical pictures, from the mildly apprehensive patient who worries a little more than he should, to the one in an acute panic reaction, who is convinced there is something terribly wrong with him.

Understanding Anxiety

A syndrome so common and ever present, must fulfill a definite role in human affairs. There are a number of explanatory theories, of which the psychoanalytic one is the most comprehensive.[1,2,3,4]

Like fear, to which it is related, anxiety seems to have a protective function. Just as fear helps with physical survival, anxiety helps in the world of interpersonal relations towards what we may describe as *emotional survival*: the ability to gain acceptance from others.

Reaction to Danger

Like fear, anxiety is a primary reaction to danger. Fear refers usually to a danger without, clearly visible to others; anxiety refers to an internal danger. Like the Trojan Horse, the anxiety attack is an assault from within.

Conflict of Emotions

Internal danger means of course, that there is strife within the person.

As a human being grows and develops, he has to acquire not only control of external circumstances, but also mastery of himself.

Most of the problems the child faces can be reduced to ways and means of integrating his own self-centered needs with those of his environment. There is always conflict between the child's egoistic love of himself, and his more altruistic love of others. It is only because the child wants the support and affection of his parents more than he desires his constant comfort, that he is able to divest himself of some of his more self-centered strivings.

Of the two forces the parents use for educating the child, love is, of course, the most important; but fear always plays a fundamental part. Both are involved in creating unendurable distress if the child does not respond by making progress along his developmental path. As one looks back, superseded and forgotten conflicts are strewn along the way, as so many discarded old cocoons.

In the process, several types of fear can be distinguished, from the earlier and more primitive, to the older and more socially sophisticated:

(1) fear of losing the parent, and parental physical care ("dependency")

(2) fear of losing the parent's love

(3) fear of being punished for one's fantasies

of an aggressive or erotic nature, involving the parents (the punishment imagined as some sort of retaliatory deprivation or damage)

(4) fear of losing self-esteem (self and social approval)

These anxieties go from a highly *personal* concern about physical bodily needs to a highly *interpersonal* fear of disapproval.

Has a mature human being overcome all of these fears? The normal person when undergoing stress, and the anxious patient all the time, they both manifest a good many facets of these developmental anxieties.

A Clinical Example

A demonstrative vignette may help make our discussion more meaningful at this point.

A 40-year-old woman, a clerical employee at the admitting office of a small hospital, was referred for psychiatric evaluation because of constant fears of a heart attack. She had been admitted to the hospital on several occasions with complaints of palpitations, intense fear, restlessness and mild chest pain.

When reassured by the doctor's examination that there was no apparent organic disease, she would calm down some, but continued to worry. Her fear then was that there might be something wrong with her which the doctor was not as yet able to detect.

Asked about her present life situation, she claimed to be happily married, and said there were no difficulties of any kind in her life. She was unable to recall exactly when and under what circumstances her apprehension had started.

Throughout a series of interviews, she was finally able to remember that the anxiety attacks had begun six months previously, on one occasion when she was in the process of helping to admit a patient. What kind of a patient? A middle aged obnoxious alcoholic man, who became very boisterous and difficult to manage. "I was revolted by his behavior, his obscene talk and his fighting." She was so mad and started shaking so badly, that she was forced to leave the room.

A brief exploration of where such intense feelings could come from disclosed the picture of a very harsh and bitter childhood at the hanls of an irresponsible alcoholic stepfather, of whom the patient's mother was dreadfully afraid. There was also a suspicion that her husband, whom she had married because he seemed so reliable, had apparently formed an extramarital liaison.

This summary allows us to review a number of typical features in the average anxious patient.

Precipitating Event

There is usually a precipitating event or situation in the patient's *present* environment, which triggers the anxiety attack. Also very typically, the patient at first denies such an occurrence. In part, she is not really aware of the problem; in part, she is trying to protect herself from having to discuss with the physician intimate details of her life, which she considers embarrassing or painful.

One should never underestimate people's capacity for self deception. To kindly insist that there must be a recent cause for the disturbance, as the doctor knows from his long experience with this type of problem, is in the best interest of the patient.

It may be misleading to always think of clear cut, highly dramatic incidents. To be sure, this is many times the case; but long term common, disturbing family situations, form always the unavoidable background.

In the patient mentioned above, the fact that the husband was apparently running around was a clear indication that not all was well with the marital relationship. Her inane statements about the good state of her marriage obviously covered up a very intense fear of being abandoned by him, and a good deal of repressed rage about his behavior.

We should not be too hard on the patient's sincerity, as we all have an almost uncanny ability to deceive ourselves about the true nature of our actions.

A married woman, who lived with her aged, cantankerous and dominating mother, attributed her anxiety spells and fatigue to a lack of adrenalin in her system. Trying to convince her physician of the soundness of her explanation, she uttered this statement, "I have so very little adrenalin circulating in my veins that if somebody came in right now and told be that my mother just died, I wouldn't be able to move a muscle!"

The physician needs adequate knowledge of the sentimental intricacies of normal human relationships, to be able to understand the patient's true emotional situation. Ambivalence of feelings, the fact that most of our intimate attachments involve a mixture of sentiments (love and hate, resentment and tenderness), is a constant finding. When the relationship is threatened (separation, jealousy), the negative feelings come to the fore. This the anxious patient perceives as a serious danger.

An 18-year-old high school senior complained of inability to urinate in the presence of others at public rest rooms. This was very embarrassing to him, as he was a very shy person, to begin with, and blushed easily in situations of this sort.

A review of his family history showed his household was composed of a psychotic father, who had severe episodes of temper and depression including suicidal behavior; and a hard suffering mother, distant and aloof, but to whom the boy felt, nevertheless, intensely attached. With some encouragement, he was able to discuss his fear of going away to college, leaving his mother, as it seemed to him, in the hands of his father. The urethral inhibition in part represented his fear of attending college with boys whom he pictured as more grown up, mature and masculine than himself.

Inhibitions of this type very commonly hide a good deal of anxiety regarding adult relationships. Some anxious girls refuse to go out with boys "because I may have to go to the bathroom, and how would I explain that to my date." Looseness of the bowels is not an unusual physical symptom of fear.

I once treated a married couple who, after six months of marriage, were still unable to tolerate each other's presence in the bathroom. Not surprisingly, their main complaint was inability to have sexual relations.

Predisposition and Fears

As one takes the history, there are generally in the anxious patient, evidences of a tense, worrisome disposition, which goes back to childhood. Sensitivity to separation from mother, as for instance expressed in so called "school phobia," is not uncommonly elucidated.

School phobia, as most pediatricians know, is a misnomer for a situation in which a youngster manifests an acute fear of leaving home to attend school. Sometimes the child openly refuses to go; more often he suffers severe nausea, vomiting, stomach ache and fever. All these dramatic symptoms are quickly alleviated if he is reassured that he can stay home. If he is forced to attend school, as it is usually done when the family receives psychiatric help, he develops severe anxiety, and pleads to be returned home.

At the root of this condition there is usually a good deal of apprehension to leave the parents, particularly the mother, lest something should happen to her. Constant watching of his mother is the only recourse the youngster is left with, to reassure himself against the imagined effects of his own resentment. Families where this type of problem develops usually disapprove very strongly of any open expression of hostility.

If clear cut phobias do not appear in the history, one often finds subtle evidences of inhibition. Patients describe themselves as little boys and girls who seem to have been better behaved than average, all of the time. Such extreme fear of disap-

THE AUTHOR

Doctor Llinas is assistant clinical professor of psychiatry at the Michigan State University College of Human Medicine.

proval is incompatible with a normally contented youngster, at least in our culture.

Somatic Preoccupation

Fears of a "heart attack," as the patient mentioned above suffered; "hypertension," "cancer," etc., are very common. They represent a convenient peg to hang apprehensions on; and very frequently mask fears of punishment related to fantasies of giving in to forbidden aggressive or sexual desires.

Without realizing it, the patient reproduces forgotten concepts of the time when he was a child, and was taught that if he behaved himself, nothing bad would ever happen to him; or the ideas of primitive people, who fear sickness as a punishment from the gods. This return to earlier, previously surmounted infantile modes of thought is called *regression,* and is a very striking characteristic of the anxious patient.

At times the situation is complicated by the presence of true organic disease.

A 43-year-old salesman was referred by his cardiologist because of the patient's seeming inability to accept the reasonable restrictions imposed by his coronary artery disease. The patient described himself as a highly driven man, who was used to working 12 to 14 hours a day; and for years had had little time or interest for anything else in his life. He was married to a very passive, inhibited, highly religious wife; they had two boys, and the patient was very strict with them.

There was an older brother, with whom the patient as a youngster had been very competitive. "He was so good in sports, and my parents liked him so well, you might say I lived under his shadow," the patient stated. He admitted being unreasonably angry about his heart condition, feeling that to have to slow down because of the illness was "adding insult to the injury."

He was unable to see or admit to himself that jealousy of and competition with his older brother were serious unresolved problems, despite the fact that in a second interview, he described many vicious fights with him. The brother was older and stronger, and "used to hit me right here, where I now get the pain."

Principles of Early Management

The anxious patient is caught in the throes of an emotional conflict within himself, which he does not understand and of which he is not even clearly aware. The anxious attack has been precipitated by an emotionally charged incident or situation, but the patient has usually "forgotten" the incident, and is leary of discussing it. There are evidences of childhood fears or apprehensions, and a good deal of somatic preoccupation. The patient is more willing to discuss symptoms, than he is life circumstances connected with them.

The Physician's Reaction

The doctor's initial response to the anxious patient determines to a large extent whether the patient will be helped or not. The patient is scared, and in a state of crisis, but the situation of danger the patient fears so much is usually not as grave and serious as he assumes.

The fear has to be accepted and understood, remembering the simplified list of developmental apprehensions listed above. The patient is a bona fide sufferer, a legitimate medical patient, and there is no point in minimizing his preoccupations.

A very common pitfall is to try to reassure too much and in too general a way. A psychiatrist of vast experience, Professor Raymond Waggoner, pointed out recently a not unusual happening between physician and nervous patient.

The patient himself may ask, "Should I see a psychiatrist, doctor?" The physician responds confidently, "A psychiatrist? Why, you are not crazy, we'll find out what's wrong with you!" At the end of a negative study, however, he is confronted with the fact that the patient does need psychiatric help.

It is much better not to prejudge, and to have a clear and open attitude about emotional problems.

Preventing Further Regression

By the time one has finished the history and physical examination, he has some understanding of the problem. This explanation should be given to the patient in terms he can understand, encouraging him to bring up any questions he may have. If one has been able to come to such a conclusion from what the patient has said, one should emphasize time and again that his symptoms reflect unresolved problems and chronic unmastered fears.

This does not preclude further examinations, and in fact it is important to keep in mind that emotional and organic problems do not exclude each other. The doctor has to carry this burden; it can not be shifted to the patient alone. The ideal situation is one of a healthy partnership, with both doctor and patient working together.

Accepting the Patient as He Is

Anxious patients are not necessarily, and certainly not immediately, reassured by a friendly and firm physician, who seems to know what he is doing. Some of these patients know only too well what murderous thoughts may be hidden behind an aura of friendliness.

Time heals; and it is of the essence in mastering problems. The doctor and the patient will have to have time to get better acquainted with each other, and learn to understand and resolve conflicts.

A woman who is tempted to divorce her abusive husband, but has a sense of obligation towards the children and is afraid to go it alone, is not going to find it easy to make a decision, even after she recognizes the real problem.

On the other hand, we know people do make decisions as difficult as this, and carry through with them, particularly if they have some encouragement and support. A beautiful novel by a psychiatric patient who recovered from schizophrenia after many years of treatment, was titled after the phrase used by her woman psychiatrist early in treatment to explain what the patient could expect. "I never" the doctor said, "promised you a rose garden!"[2]

Reluctant, withdrawn or very frightened patients who take their time to warm up to any kind of relationship, teach the physician the old virtue of the obstetrician, patience. The larger the number of anxious individuals the doctor sees, understands and treats, the easier it becomes to manage them scientifically.

Relatives

It is always useful to see important relatives, either by themselves or accompanied by the patient; and a similar tactful attitude is necessary with them. If their questions are truthfully answered, and they are ready to listen, one can correct many common misconceptions.

The idea that physical symptoms may spring from disturbed relationships to others is a new and threatening one for most people; it forces them to face feelings and thoughts that are usually not pleasant. And yet, if there is to be any relief to the situation, the interpersonal difficulties have to be resolved.

Prevention

It is not an idle exaggeration to say that all patients who come to a physician for help are potentially anxious patients. Unfortunately, many times the physician complicates the problem by over-reacting to it.

A 20-year-old pregnant housewife with mild anxiety symptoms was seen in the hospital after she "went to pieces." In discussing with her obstetrician her fears regarding delivery, he abruptly cut her off and declared that she "belonged on the fifth floor" (the psychiatric unit.) Acceptance of her many fears, and her right to express them, brought immediate relief to her face. She compared this incident with another experience she

had as a very scrupulous adolescent, when an understanding minister had reassured her about her fears of sin and sexuality.

Prognosis

Anxiety can, in some ways, be compared to fever; the presence of moderate anxiety indicates a reasonably well functioning mind. If the patient trusts the physician, and the physician can tolerate the anxiety compassionately, without over-reacting to it, the prognosis is good. One does not try to suppress fever, except when the fever is high or otherwise troublesome, unless one has some idea of its etiology.

With good psychiatric consultation available, the physician can handle the vast majority of uncomplicated cases of anxiety. Even when he refers patients to the psychiatrist, his interest and collaboration with the specialist can do a great deal to get the patient on the road to recovery, and further emotional growth.

Summary

The anxious patient presents a syndrome characterized by signs and symptoms of fear, but he usually does not know the cause of his apprehension. There is commonly a situation in the patient's environment which he perceives as dangerous, because it stimulates forbidden feelings within himself.

It is the physician's function to first understand the situation, and then slowly convey his knowledge to the patient, within the framework of a trusting doctor-patient relationship. If this can be done, improvement usually follows. □

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Employing the Diabetic

Like the legendary Phoenix new problems rise from the ashes of problems solved. Such is the situation in employment for the diabetic.

Fifty years ago, diabetes in a child or young adult meant total invalidism and early death. Today, with the proper use of insulin and oral hypoglycemic agents, diet and education, diabetics can expect a long life with uninterrupted periods of full activity. Though morbidity may be higher with inadequate metabolic control, the average diabetic rightfully shares the hopes and aspirations of his non-diabetic peer.

One hope is regular employment.

Yet nowadays, the certainty of employment for the otherwise healthy diabetic remains elusive because there exist problems real to both the employer and employee.

The likelihood of employment relates to jobs available, to individual ability, to an assurance of minimal absenteeism and to the potential financial liability assumed by the employer. In a tight labor market with many jobs and few applicants, the employer will overlook certain deficiencies in the employee as long as he can do the work. When a plethora of applicants exist, the qualifications of the individual are more carefully scrutinized. Individual ability means what a man offers to the labor market. Thus, the skilled worker or specialist rarely wants for work while obversely, the semiskilled or unskilled laborer often is unemployable.

The cost of benefits which may accrue to an employee from his group insurance, pension plan or workmen's compensation may affect his employability and may restrict the selectivity of the employer. Thus some employers may not hire certain workers because of "third-party restrictions." In many large industries, hiring involves more than the desire of a man to work and of a boss to hire.

Employment without regard to health and ability is not a right. Diabetics must understand this. They are wise to obtain as much education as possible. Not only should they aspire to positions where the vagaries of their disease are minimized, but they must also achieve a work record of high quality so that their non-diabetic fellow-workers and employers will learn that diabetics are worthy of their hire.

Employers should not prejudge diabetics; let them judge each man's potentiality and performance individually. Prejudices toward employability should not result from one or two bad experiences.

Should an inept left-handed employee jeopardize the employability of all southpaws?

Indeed not, nor does it follow that one diabetic with a high absentee rate mirrors the performance of all diabetics. Let all employers individualize the diabetic applicant. Though all the applicants have the same metabolic disease, varying degrees of severity and potential hazard exist. We feel that unconditional refusal to consider the employment of any diabetic is anachronistic. We want to persuade employers that this opinion is reasonable and defensible. Evidence exists showing equal absenteeism in diabetic workers when compared with employees without diabetes.

To help employers judge the applicant with diabetes on an individual basis, the Michigan Diabetes Association has developed an "Employment Classification." We hope it will serve as a guide toward unbiased judgment of the diabetic applicant by helping the employer individualize his decision.

The degree of severity of an applicant's diabetes together with the frequency of his visits to his physician serve as the basis of the Classification (Table 1). Thus the insulin-dependent diabetic (III-IV) should visit his physician more often than the mild diabetic (I). Generally the more often, within reason, a diabetic visits his physician for medical evaluation, the better will be the regulation of his diabetes. Greater stability means fewer medical problems may develop which might interfere with his employment record or create a work hazard. We know also that the optimal frequency of visits to a physician by a diabetic relates to the nature of his diabetes.

While the severe diabetic needs insulin, in the milder diabetic a diet alone or the concomitant use of an oral blood-sugar-lowering agent will suffice. Diabetics in the latter category usually in-

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This is a statement prepared by the Michigan Diabetes Association Committee on Employment. The approach is practical and highly commendable as a model to be followed by others similarly concerned with employing people with handicaps of a chronic nature. Members of the Committee are Fred W. Whitehouse, M.D., Chairman; Nelson Taylor, M.D.; George Thostenson, M.D.; Douglas Wood, M.D.; William Jend, M.D.; William L. Lowrie, M.D.; and Martin Burton, M.D.

— *The Editor*

DIABETES AND EMPLOYABILITY: CLASSIFICATION

Current Treatment Status of Diabetes	History of Professional Care A Sees Physician at least four times a year	B Sees Physician as necessary, but at least once a year	C Sees Physician less than once a year
I. Diet Alone	1	1	2
II. Diet and Oral blood-sugar-lowering agent	2	3	4
III. Diet and Insulin	3	4	5
IV. History of Frequent Hypoglycemic Episodes	4	5	6

This scale is an index of the relative stability of the applicant's diabetes. The scale ranges from Grade 1. (most favorable for employment) through Grade 6. (least favorable for employment). Factors such as job hazard, the Company's employment policy, insurance status, etc., must be considered on an individual basis.

clude those workers who develop their disease in middle-life after years of fruitful employment. The former group, the younger diabetics, present greater vulnerability, yet more frequent visits to a physician by this diabetic seem to offer greater physical stability.

By using this classification, we hope employers and their medical advisors will feel more confident in their evaluation of the individual applicant with diabetes. This classification will not answer all individual problems; no classification will do that. However, we hope use of this classification will permit one to judge a diabetic individually rather than as an unidentifiable member of a large group.

Some physicians may object to this classification because the degree of metabolic control is unspecified. What is control? Even experienced physicians disagree. This classification assumes that control of the diabetes will be affected by the regularity with which a diabetic visits his physician. The more insulin-dependent the diabetes, the more often the diabetic should visit his physician for re-evaluation of the diabetic state.

Others may say that nowhere do we mention the complications of diabetes. If there be neuropathy, diminished vision, or a circulatory problem, consider this on its own merit (or demerit). We believe that a complex classification with awkward criteria will hinder its applicability. This classification seems sufficiently practical to warrant a trial. The Michigan Diabetes Association hopes to do this. We hope individual physicians who face the problem of giving opinions on risks or lack of them in hiring the diabetic will use this classification. Any physician may obtain copies from the Michigan Diabetes Association. ☐

American Medical Care —Fact and Fancy

BY PAUL S. FRIEDMAN, M.D.
PHILADELPHIA

We, the physicians of America, are eager to participate in a continuing dialogue with the American people, so that through our combined efforts, the best medical care at the lowest possible cost will result. We particularly want to bare to the American people our goals, our aspirations, and our accomplishments, from a vantage point of truth, to serve better the people of the United States.

The medical profession welcomes constructive efforts at criticism. In fact, it participates in self-evaluation continually. Certain critics and criticisms, however, are unjust. Instead of collecting the facts objectively, and drawing conclusions from them, some critics start with unfair prejudgments, and then distort the facts, creating untruths and half-truths to support their conclusions. It is our responsibility to our patients that demands that we correct this misinformation, for such misleading information can be damaging to them when they are being treated, causing confusion and distrust.

The following are just a few examples of these unfair criticisms and the facts about them.

Number of medical colleges, medical students, and physician population.

It has been unfairly maintained that the medical profession and the American Medical Association are attempting to restrict the number of medical colleges and students. The reverse is true. The American Medical Association has stimulated new schools, frequently advising groups, planning and developing new schools. Since 1947, 11 new schools have opened, totaling 88; and by 1970 an additional 13 will be in operation, totaling 101. Six more are assured and another six are possible by 1975.

The American Medical Association supported legislation providing federal funds for medical college construction.

In addition, the American Medical Association and its branches, the state and county medical societies, have embarked on recruiting programs for medical students.

The American Medical Association has established a loan guarantee fund, to give financial assistance to medical students, interns and residents, supported by voluntary contributions of physicians, medical associations, private companies, and foundations. Over $35 million have been lent since the fund's founding in 1962. In addition, loan funds are available through state and county medical societies.

In 1960, there was one physician for 737 people; in 1965, there was one for every 681, a faster rate of growth in physician population than general population.

In the past, efforts to predict future physician needs have been most inaccurate. In 1959, the Bane Committee gloomily predicted we should never reach by 1975, the needed total of 330,000 physicians including osteopathic physicians. Actually, there will be a minimum of 360,000 physicians by 1975, exclusive of osteopathic physicians.

There has, however, been a functional and geographic maldistribution of physicians. There has been a marked reduction in the number of family physicians. This has been strongly influenced by the tremendous overemphasis on specialization and research in the medical colleges, largely stimulated by the unbalanced influx of federal funds into these areas. At the present time, efforts are being made to restore the family physician to his central role in American medical care.

An American Board of Family Medicine has been created and the American Medical Association has recognized Family Medicine as a specialty in medical practice. Recently, the American Medical Association commissioned a Report of a Citizens Commission on Graduate Medical Education. Many recommendations are to be implemented, such as a residency training program in family medicine, encouragement of group practice among family physicians and others, staff appointments and full practice privileges for family physicians on hospital staffs, as well as integrated programs in medical colleges, staffed by family physicians, to stimulate training and interest in family medicine.

There has been a tendency for physicians to concentrate in metropolitan areas, with resultant

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(Editor's Note: This article is reprinted with the permission of both the Nebraska State Medical Journal and the author.)

diminished concentration in other areas. To offset this, the American Medical Association in conjunction with the Sears Roebuck Foundation has been sponsoring rural location of physicians. The Kansas Rural Health program, developed by Dr. Franklin Murphy, has been most successful, in supplying rural medical needs. It involved the enlargement of the capacity of the Kansas Medical School to train medical students, the creation, through voluntary local fund raising, of facilities for medical practice throughout the state. Then a program of continuing education for rural physicians was set up consisting of two parts: 1. Traveling teams of consultants originate from the medical college and hospital, to visit different areas of the state throughout the year, holding clinics and offering consultation. 2. Rural physicians return to the medical college periodically for several weeks to months of refreshing training.

Many state societies have placement programs for physicians. Emergency medical services have been instituted by many county medical societies.

In addition, the tendency to overload full time staffs of medical colleges and larger hospitals must be reversed; this, too, is contributing to the maldistribution of our younger physicians.

Quality of medical care. Improperly documented criticisms of the quality of American medical care have been publicized. In many cases, these have used data originating in articles written by physicians, for self-evaluation and for education of their colleagues; incomplete information has been abstracted to support untrue conclusions.

A published article has been referred to as reporting that 90% of 21 surgical deaths in infants and children was the result of doctor error, and therefore evidence of poor medical care. But this study involved more than 4,000 operations in a single hospital, over a 10 year period beginning in 1947, 20 years ago; among the 21 there were many serious abnormalities at birth; and the article further stated, "There has been a dramatic decrease in operative deaths during the past four years, 1958-1961."

In other cases, efforts are made by critics to use statistics, usually from England and Sweden, to attempt to prove that the practice of medicine in the United States is inferior. Actually, if true statistical comparison can be made, it demonstrates that American medicine is second to none.

Basically, however, when comparison is made between one nation's statistics and another, comparisons may not be occurring between exactly the same events.

For example, Sweden's infant mortality rate is 1% below that of the United States. But, in Sweden, a baby is not alive until he breathes; such a baby's death would be called foetal death. In the United States, the presence of a heart beat or voluntary motion would classify the baby as alive, and subsequent death would be classified as infant mortality. Furthermore, the frequent use of abortion, in Sweden, alters these statistics further.

Further, while it is true that the average Swede lives to age 73, and the average American to the age of 70.3, a Swede in Minnesota outlives a Swede in Sweden.

As Waldo Von Greyerz, M.D., Swedish delegate to the World Medical Association pointed out, "I don't know how you would compare medicine in Sweden . . . with medicine in America. It surely can't be done with infant mortality and longevity statistics. People who compare such things obviously are hunting for headlines."

There are numerous other areas in which similar unfair criticism is publicized. These include the relation of physicians' fees to the rise in cost of medical care, the position of the medical profession and the American Medical Association to change and new legislation, the need for further governmental involvement in the distribution of medical care, among others. There is no question that continuous change and improvement is necessary to keep the quality of medical care in the United States at its high level and keep the cost as low as possible. The physicians of America are committed to that goal.

Let us remember, however, that the medical encounter involves the relation between a patient in distress and a physician equipped mentally, spiritually, and technically to relieve that distress and to prevent its occurrence. In making changes, let us preserve this as the basic component of high quality care.

The people of America are fortunate in having the finest medical care structure the world has ever seen. Let us recall that this has resulted because of the basic emphasis upon the individual patient physician encounter, with the physician basically and primarily responsible to that patient. Let us recall that this development has occurred in a basically private enterprise system, with the vast proportion of the financial support coming from private funds. Let us recall that nowhere else has there been such a development of voluntary nongovernmental health insurance. Let us remember that in those countries where the influence of government through the use of tax funds and control, has become dominant in the medical structure, that the quality of medical care has declined and the cost has excessively risen.

There is much to be done. There is a great need to restore the family physician to his primary position in American medical care; there is a great need to foster increased group activities among physicians, but always preserving the basic physician patient bond; there is a related need to restructure the medical college curriculum to reduce the emphasis upon accumulation of unending data by the student, with accompanying emphasis upon scientific knowledge as an end in itself, and return to basic principles with emphasis upon the humane and spiritual goals of the physician, using scientific knowledge as a tool for the help of patients. Related to this, there is the requirement that funds be redistributed in the medical colleges to meet these goals; the family physician must be given a position of significance and responsibility in both the hospital and medical college; with the resultant deemphasis upon unnecessary consultation and unnecessary laboratory studies, often done as a routine, rather than as indicated. As this is done, cost will be reduced; investigation and research must be supported, but not to the exclusion of providing individualized high quality patient care; the voluntary health insurance program (commercial insurance, Blue Cross-Blue Shield) must be continually expanded and strengthened to help the American citizen provide for the cost of medical care; government participation through the use of tax funds should be limited to those who financially require such help, and should be furnished through the states; governmental control and intervention should be resisted and minimized. There are many other vital goals.

Let all of us, physicians and citizens of the United States, join in a continuous program of change to improve further the quality of medical care and reduce the cost as much as possible. Let us guard against change, however, which will destroy the basic ingredients which have made American medicine great. □

Children's Bureau Lists Possible Issues for '70 Michigan Conference

Plans for the 1970 Michigan White House Conference on Children and Youth are being developed now by the Michigan Youth Commission.

The conference planning committee has decided to build its work around the age group of "Minus Zero to Five Years." The conference will study how these small children and their parents "are affected by the tensions, concerns and anxieties of depravation and affluence."

Medical society leaders will be interested in six suggested conference issues proposed by the Federal Children's Bureau for the 50 state conferences. The six issues included:

"1. How it is possible to satisfy the growing urge on the part of the youth for direct participation in decision-making in those areas which directly affect them, and still maintain clearly established areas for final authority?

"2. In what ways should legal protection and rights of children and youth be strengthened or modified?

"3. Where does the youth's individual right and responsibility for defining the limits of sexual behavior leave off, and the societal begin?

"4. How can the numerous educational tasks in the society be distributed so that young people have access to the learning situations they want and need?

"5. What frontiers of individuality should today's children and youth seek?

"6. How can we redirect our societal dynamics in order to emphasize human development?" □

Special "Ars Medica" Exhibition Being Brought to Detroit as Feature For MSMS 1968 Annual Session

BY ELLEN SHARP

CURATOR OF GRAPHIC ARTS
DETROIT INSTITUTE OF ARTS

Ars Medica is the title of an exhibition of prints depicting medical subjects which will be shown at The Detroit Institute of Arts from September 22 through October 20, 1968. This exhibition has been arranged in cooperation with the Institute's Department of Graphic Arts and a special committee of physicians especially for the 1968 Annual Session of the Michigan State Medical Society in Detroit, September 25-26.

The exhibition will consist of over 130 original works of art representing all types of graphic media—woodcuts, engravings, etchings, lighographs and serigraphs. The prints are grouped in 21 different categories.

SOME OF THE subjects covered are Hospitals in Peace and War, Hygiene and Preventive Medicine, Medical Teaching, The Madhouse, and Allegories of the Healing Arts.

One of the earliest prints in the exhibition is a woodcut from Ketham's *Fasciculus Medicinae* published in Venice in 1493. Entitled "The Zodiac Man" it is the oldest printed bloodletting chart.

A fine impression of the first etching by the great German graphic artist, Albrecht Durer, *Plate of Sketches,* depicts the four temperaments (or dominant humors) — the choleric, sanguine, melancholic and phlegmatic.

A Sixteenth-century etching by Abraham Bosse illustrates one of the commonest therapeutic measures of that era — phlebotomy. This print is characteristic of Bosse's work showing the life of the upper middle class in France with a wealth of detail.

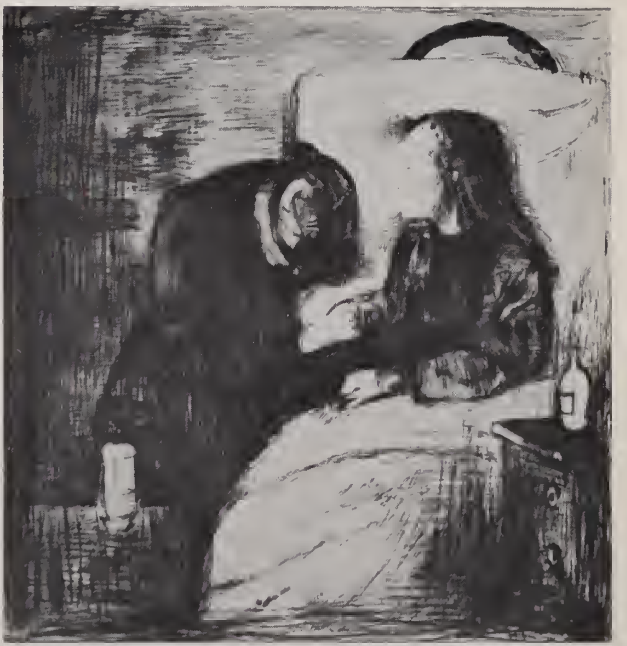
A pioneer example of color printing, developed in the Eighteenth century, is Jacques Gautier Dagoty's mezzotint *Muscles of the Head,* plate I from *L'Anatomie de la Tete,* Paris, 1748.

The great caricaturists and humorists of the eighteenth and nineteenth centuries did not neglect the medical profession. Thomas Rowlandson, George Cruikshank, James Gillray, Gavarni, and Honore' Daumier are represented in the exhibition.

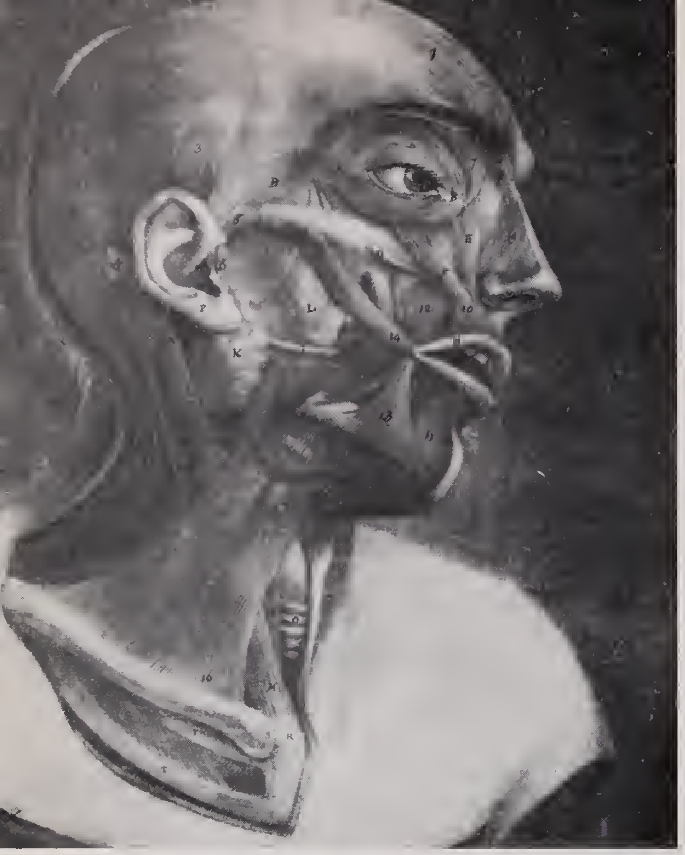
Moving and powerful works by modern artists with medical themes are prints by Edvard Munch, Kathe Kollwitz and Michael Mazur.

SOME OF THE MOST interesting prints in the exhibition are portraits of great physicians of the past, such as Paracelsus, Ambroise Pare', Andreas Vesalius, William Harvey, and Carolus Linnaeus.

One section of the exhibition reminds us that medical men often have distinguished themselves in the arts. Especially notable have been the contributions of members of the medical profession to literature. Engraved portraits of Francois Rabelais, French writer and a member of the faculty of the great medical school of Montpellier, and of



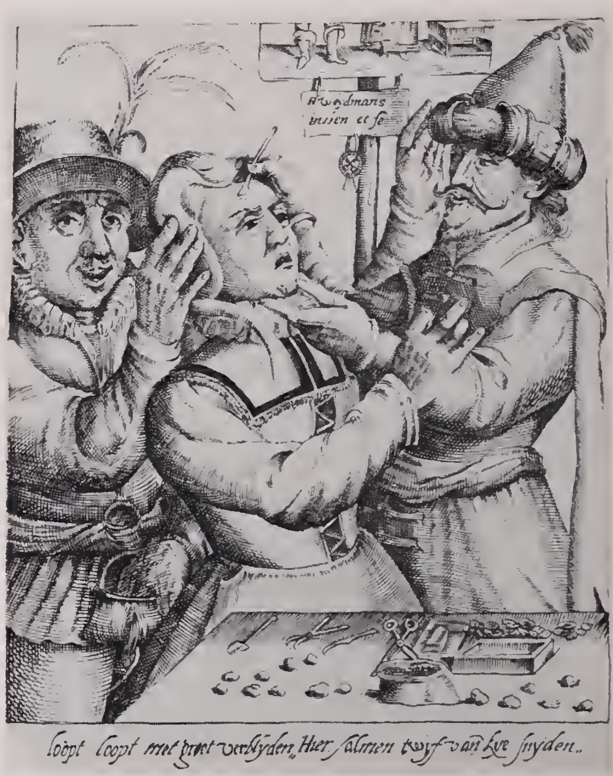
The Sick Child 1894, a drypoint, was made by Edward Munch (Norwegian, 1863-1944). Drypoint is a process often combined with engraving and etching. A metal tool with a tapered point is used to scratch the design on the plate. The burr raised on the plate on each side of the line created by the drypoint tool produces a soft, blurred line quite different from the sharp, swelling line of the engraver's burin, or the flowing, thread-like etched line.

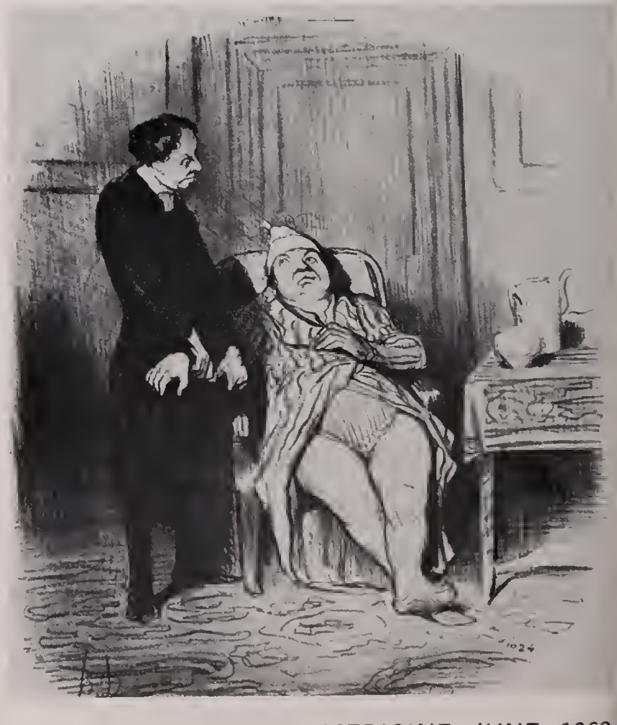


The Muscles of the Head, plate I of **L'Anaotomie de la Tete,** Paris, 1748, is a mezzotint printed in color by Jacques Gautier D'Agoty. A mezzotint is a print produced by a variant of the engraving process, developed to produce tone. A metal plate is roughened uniformly with a tool called a rocker which has a curved, serrated head; gradations of tone are obtained by scraping and burnishing away the roughened surface. The process, invented in the seventeenth century, was used extensively in the eighteenth century.

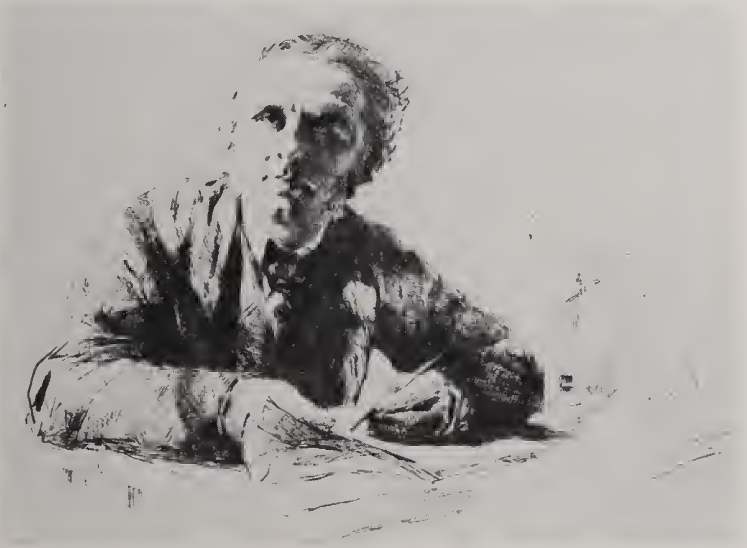
"Oh Doctor, I'm sure I'm consumptive" says the patient in this lithograph by Honore' Daumier (French 1808-1879). This appeared in a series **All One Could Wish For (Tout ce qui' on voudra),** Paris, 1847. Lithographs are made from a stone block (or zinc plate) on which the areas of the design have been drawn with a greasy substance applied by pen, brush or crayon. The design then is fixed in the stone by treating it with acid and gum arabic. For printing the surface of the stone is dampened and then rolled with greasy ink. The greasy ink adheres to the grease of the image and is repelled by the dampness from the rest of the surface. The inked stone is then printed in a press in which sliding pressure is applied rather than rolling pressure as in an etching press. For color printing, a separate stone is used for each color.

Operation for Stones in the Head, an engraving, was done by H. Weydmans (Dutch, early 17th Century). An engraving is a print taken from a metal plate on which the design has been incised with a sharp instrument, the burin or graver. The incised plate is inked, wiped and printed. The successful printing of a metal plate requires the pressure of a double-roller press to force the paper into the incised, inked lines.


H.Weydmans
incisen et fe
loopt loopt met groot verblyden, Hier salmen twijf van kye snyden..



Self-Portrait 1862 is an etching by Sir Francis Seymour Haden, (English, 1818-1910). An etching is a print pulled from a metal plate which was first covered with an acid-resistant ground. The design is drawn through the ground with an etching needle. When the plate is immersed in acid, the plate is etched wherever the metal has been exposed by the needle. The plate is inked and printed in the same manner as an engraving. If the etcher wishes to reinforce certain lines on his etched plate, he repeats the etching process. That part of the plate not to be re-etched is covered with a stopping-out varnish before it is immersed in the acid bath.



Ellen Sharp, author of this article, is curator of graphic arts for the Detroit Institute of Art, shown at right. Miss Sharp, in presenting this special exhibition, has worked closely with a group of Detroit area physicians and wives interested in art. The key man in giving the go-ahead to the project was Willis Woods, director of the Institute of Art.

Sir Thomas Browne, the English philosopher and physician, will be shown in the exhibition.

The fine etched self-portrait by the distinguished surgeon Sir Francis Seymour Haden who was also a master of etching, takes on greater meaning for the viewer when it is considered in the light of Haden's own remarks in a lecture to the Royal Society of Painter-Etchers and Engravers:

"How much sooner would the eye — accustomed to observe and estimate closely the differences of color, aspect, weight and symmetry — learn to gauge their aberrations as the signs which make up the *facies* of the disease; how much better the hand, trained to portray them accurately, be able to direct with precision and safety the course of the knife!"

THE EXHIBITION COMES in its entirety from the permanent collection of the Philadelphia Museum of Art. Through the generosity of Smith Kline & French Laboratories, a special fund was created in 1948 for the purchase of prints of medical interest. Only one condition was placed by this pharmaceutical firm on its gift, namely that the objects acquired be worthy of inclusion in a museum collection. The choice was left entirely to the curator of prints at the Philadelphia Museum. The result is not only a collection showing the essential aspects of medical iconography in all its fascinating variety but also a group of prints distinguished for their fine impressions and high artistic quality.

Recently The Philadelphia Museum has announced the establishment of an Ars Medica Center at the Museum. This has been made possible by a major grant from the Smith Kline and French Foundation. Plans are underway not only to enlarge the collection of prints and drawings relating to the medical sciences but also to develop a reference file and an information retrieval system.

MOST OF THE principal "hand methods" of making prints are represented in the exhibition. The history of Western printmaking begins in the fifteenth century as paper, which had been first made in Spain in the twelfth century, became generally available throughout Europe. The first technique to be developed was the woodcut. It was closely followed by engraving and later etching. Lithography was not discovered until the end of the eighteenth century; silk-screen printing is a twentieth-century refinement of the stencil process.

THE PRINTS IN the *Ars Medica* exhibition will include prints made by other processes in addition to the examples reproduced in this article. The other processes include:

WOODCUT on the cover, to help promote the *Ars Medica* exhibition at The Detroit Institute of Arts during the 1968 MSMS Annual Session in Detroit in September, is attributed to the Woodshop of Titian (Italian 1477-1576), entitled *The Ninth Plate of Muscles* appeared in Vesalivs's *De Humani Corporis* Fabrica, Basle, 1543. The areas not to be printed were cut away from the woodblock and the prints were made by applying ink to the raised surfaces and applying hand pressure.

AQUATINT — a print produced by a variation of the etching process. Areas of tone are obtained by covering the plate with rosin dust, then heating it so that the particles adhere to the plate. The plate is immersed in acid and is etched wherever the particles have left the plate exposed.

SILKSCREEN (OR SERIGRAPH) — a variation of the stencil process. A finely-woven fabric, usually silk or nylon, is stretched over a wooden frame to form "the screen." An image or design is created by making some parts of the screen opaque and others open. Color pigment is then forced through the fine mesh of the open parts of the stencil by the use of a tool called a "squeegee."

The processes used for the prints reproduced in this article are explained under each print.

COOPERATIVE PROJECT . . .

This special *Ars Medica* Exhibition is being brought to Detroit September 22 through October 20 by the Detroit Institute of Arts and a group of Detroit area physicians and wives interested in art. The group has contributed the funds necessary to transport the exhibition from The Philadelphia Museum to Detroit so the exhibit can be an added attraction for the 1968 MSMS Annual Scientific Session, September 25-26. Members of the co-sponsoring group include Dr. and Mrs. Irvin F. Burton, Dr. and Mrs. Alfred Golden, Dr. and Mrs. James J. Lightbody, Dr. and Mrs. Paul E. Mattman, and Dr. and Mrs. Milton R. Weed.

et's be specific about Campbell's Soups...
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
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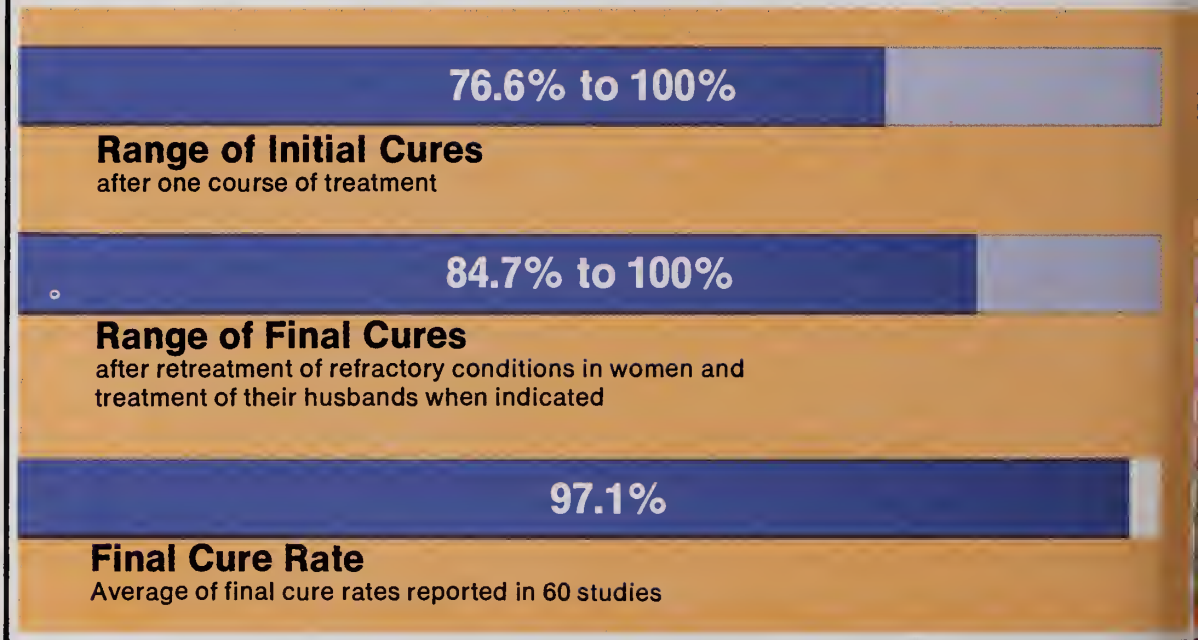
Campbell's
CONDENSED
SOUP

True Drug Failure..

How often does it occu

Cure rates in 10,700 patients
treated for trichomoniasis with *Flagyl* and reported in
60 papers published in the United States.



Indications: Flagyl is indicated only in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry ton
Gastrointestinal disturbances, flushing and h
ache sometimes occur, especially with con
itant ingestion of alcohol. The taste of alcol
beverages may be altered. Other effects, al
ported in an incidence of less than 1 per cent
diarrhea, dizziness, vaginal dryness and bur
dry mouth, rash, urticaria, gastritis, drowsi
insomnia, pruritus, sore tongue, darkened u
anorexia, vomiting, epigastric distress, dys
depression, vertigo, incoordination, ataxia,

ith Flagyl®?

brand of

metronidazole

nical practice an occasional uncooperative or drug-sensitive patient
use makes 100 per cent cure of trichomonal vaginitis in large series
ients difficult.

Further a very few patients who apparently absorb Flagyl poorly
few rare instances of trichomonads resistant to Flagyl have been
ted. Nevertheless, approximately half the United States investiga-
port a final cure rate of 100 per cent with Flagyl.

ixty papers[1] published on the use of Flagyl in trichomoniasis in the
d States and comprising a total of 10,700 patients have been evalu-
In thirty of the papers it was declared that all patients adequately
ed and treated were free of trichomonal infection.

nalysis of all of these papers shows that the incidence of cures for
itial course of therapy ranged from 76.6 per cent to 100 per cent.
ure rates after retreatment of female patients and treatment of their
nds when indicated ranged from 84.7 to 100 per cent. The average
ure rate reported in all investigations was 97.1 per cent.

ial cramping, constipation, stomatitis,
ess or paresthesia of an extremity, joint
confusion, irritability, weakness, cystitis,
pressure, dyspareunia, fever, polyuria, in-
nce, decreased libido, nasal congestion,
s and pyuria. Elimination of trichomonads
gravate candidiasis.
and Administration: In women: one
. oral tablet three times daily for ten days.
al insert of 500 mg. is available for local
when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

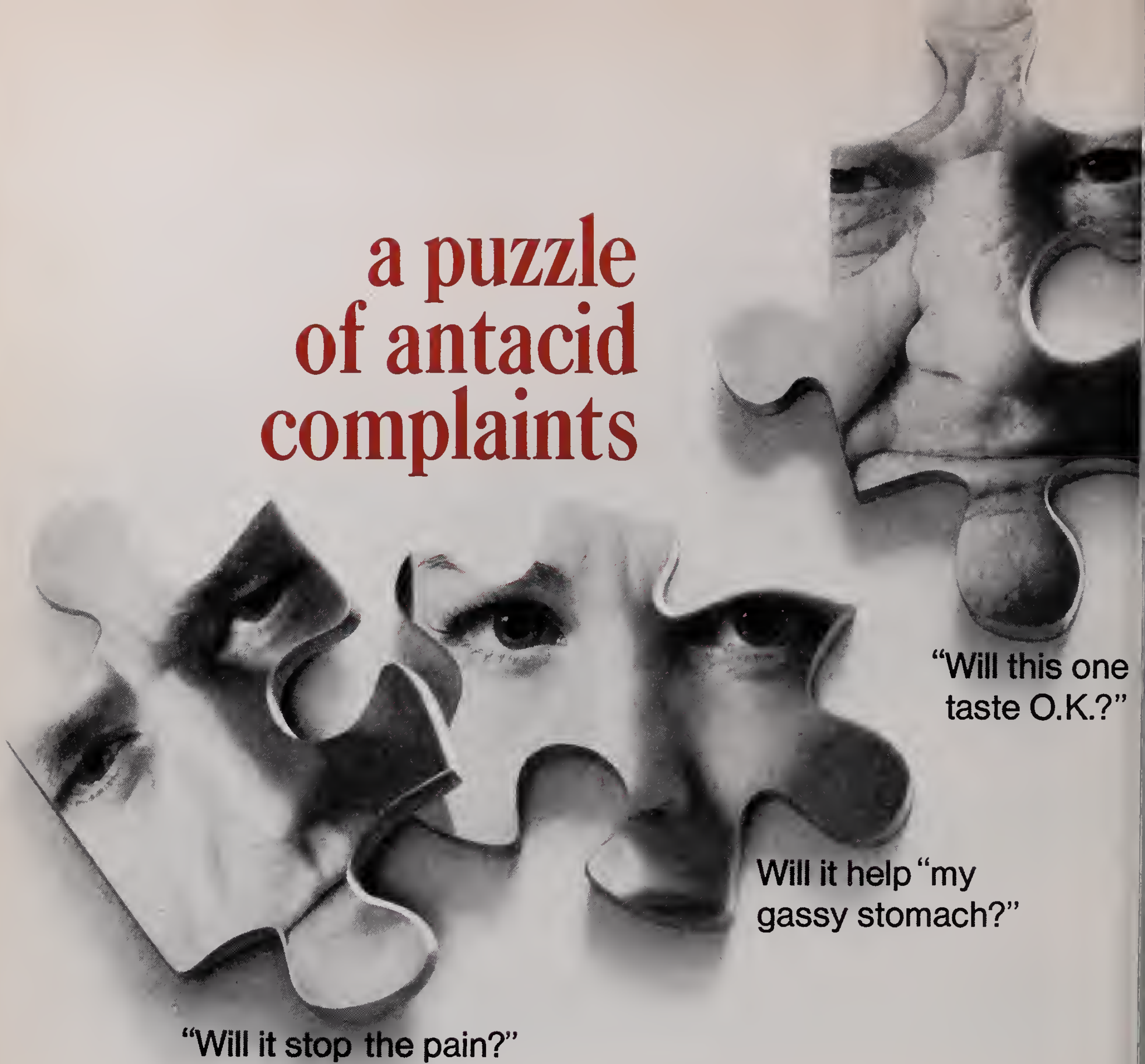
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets–250 mg.
Vaginal inserts–500 mg.

1. Complete list of references on request.

SEARLE *Research in the Service of Medicine*

a puzzle
of antacid
complaints


"Will this one
taste O.K.?"
Will it help "my
gassy stomach?"
"Will it stop the pain?"

Mylanta®
aluminum and magnesium hydroxide *plus* simethicone

a solution
to peptic ulcer
distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethico

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonfu (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 m Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Invite Nominations For MSMS Honors

July 1 will be the deadline for component county medical societies which wish to offer nominees for the MSMS "Outstanding Physician of the Year Award" and for the MSMS "Certificates of Commendations."

The nomination forms and covering letters recently were sent to every county society.

D. Bonta Hiscoe, M.D., Lansing, is chairman of the committee to select the outstanding physician and Marjorie P. Meyers, M.D., Detroit, will direct the work of the other committee. Both were appointed by MSMS Speaker James B. Blodgett, M.D.

OUTSTANDING PHYSICIAN AWARD

The 1964 House of Delegates took action to establish annual recognition of Michigan's Outstanding Physician and the award was presented in 1965 to F. L. Troost, M.D., in 1966 posthumously to William A. Hyland, M.D., and in 1967 to Henry Cook, M.D., Flint.

The resolution adopted in 1964 by the Delegates provided that this recognition be given to a member of the profession, "who is not necessarily a family physician, nor one advanced in years . . ." The resolution resolved also "that consideration be given to the physician's civic accomplishments as well as his professional accomplishments."

CERTIFICATES OF COMMENDATION

The 1961 House of Delegates, in approving the Certificates of Commendation, pointed out that the new award "may include both scientific and/or public service and may be awarded to one or more physicians annually who distinguish themselves in the medical profession."

The House of Delegates has approved the recommendations each year of the Committee. The names of previous recipients are listed below:

1962

Jerome W. Conn, M.D., Ann Arbor
G. D. Cummings, M.D., Lansing
Charles S. Kennedy, M.D., Detroit
Robert L. Novy, M.D., Detroit

1963

Forest D. Dodrill, M.D., Bloomfield Hills
Charles J. Jentgen, M.D., Detroit
John M. Sheldon, M.D., Ann Arbor
Homer H. Stryker, M.D., Kalamazoo

1964

Goldie B. Corneliuson, M.D., Lansing
John S. DeTar, M.D., Milan
Robert M. Heavenrich, M.D., Saginaw
Norman F. Miller, M.D., Ann Arbor
E. Gifford Upjohn, M.D., Kalamazoo
Orus R. Yoder, M.D., Ypsilanti

1965

Fred J. Hodges, M.D., Ann Arbor
Traian Leucutia, M.D., Detroit
Remus J. Robinson, M.D., Detroit

1966

Arthur C. Curtis, M.D., Ann Arbor
Lionel L. Davis, M.D., Mt. Pleasant
Mark Marshall, M.D., Ann Arbor
Harold J. Meier, M.D., Coldwater
Ralph H. Pino, M.D., Detroit
Alfred B. Swanson, M.D., Grand Rapids
Harry A. Towsley, M.D., Ann Arbor

1967

Frank J. Busch, M.D., Saginaw
Willis Herbert Huron, M.D., Iron Mountain
Frederick J. Margolis, M.D., Kalamazoo
David I. Sugar, M.D., Detroit, (posthumously)
Raymond W. Waggoner, M.D., Ann Arbor
Charles H. Wright, M.D., Detroit

Sees Health Manpower Recruitment as Job For the Community

Recruitment to provide the right kind of persons to fill the rural health needs in Michigan and the nation "must be a total community effort," Robert E. Rice, M.D., Chairman of the MSMS Committee on Rural Medical Service, recently wrote to the MSMS Council.

Doctor Rice served recently as the MSMS representative to the National Conference on Rural Health in Seattle.

Doctor Rice, in his conference report to The MSMS Council, suggested eight possible implications for Michigan:

1. Develop more intensive and extensive First Aid Training.

2. Improve and coordinate emergency communications.

3. Improve transportation of injured.

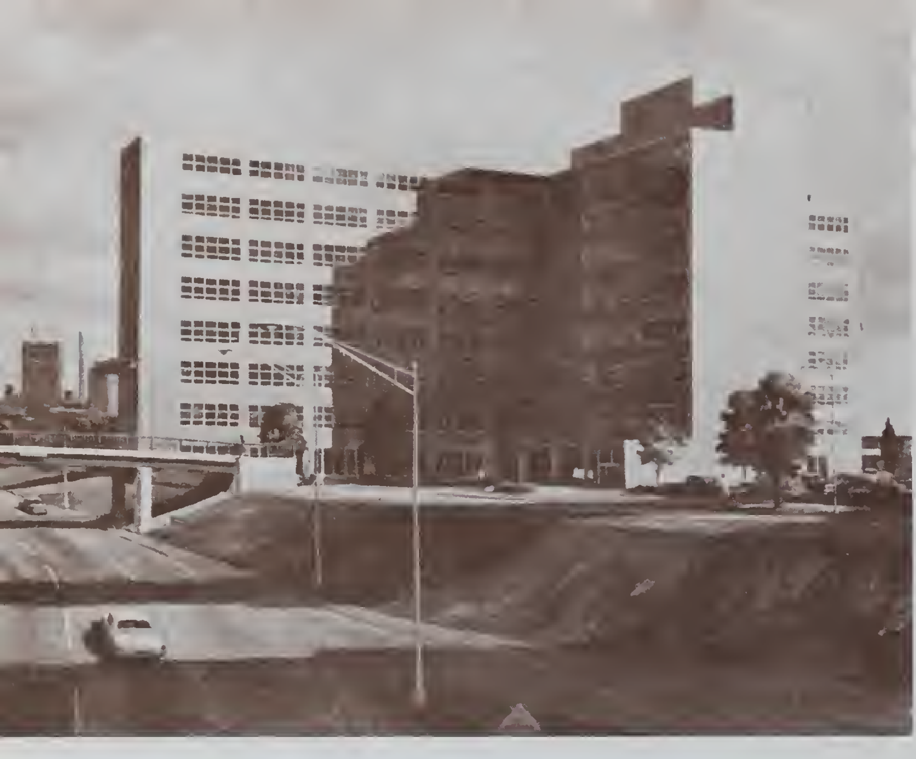
4. Meld the will of people and needs of people with know-how of specialist.

5. Anticipate variegated forms of providing health care.

6. Develop awareness of needs of providers of medical care and other health care in communities, especially rural.

7. Continue to improve dissemination of medical knowledge to profession.

8. Include health care planning in total community planning.



SQUIBB PRESENTS WSU PAINTING TO HELP OBSERVE CENTENNIAL

E. R. Squibb and Sons, Inc., recently presented as part of the WSU Centennial, an original oil painting of the Wayne State University School of Medicine to its dean, Ernest D. Gardner, M.D.

Representing Squibb was Raymond J. Powers, Squibb vice president for market planning.

The painting which shows the Basic Science Building is the work of the well-known artist, Robert Lavin.

Dean Gardner felt that this particular view would be lastingly and sentimentally remembered by every graduate.

The painting is part of a long-range Squibb plan to create a collection of original oil paintings representative of the medical schools of America.

The U-M received a painting last year during its Sesquicentennial.

AMA Aids SAMA In Pilot Effort

A student-to-people project to communicate health information to residents of lower income indigent neighborhoods was announced at the recent SAMA annual meeting in Detroit.

David Kindig, SAMA president, announced that the AMA is financing a $39,000 pilot project in Kansas City to utilize freshmen in high school up to graduate medical students to personally contact and work with residents of indigent areas and inform them of existing medical facilities available to them.

SAMA will administer the project and its Kansas City chapter will spearhead the effort in cooperation with other local organizations.

"In Kansas City, medical students have managed to smash the wall of mistrust between the 'haves' and 'have-nots' by demonstrating a determination and willingness to work with the people on their terms, in their neighborhoods," said Kindig in his comments to the SAMA convention.

MSMAS Plans July Seminar

"Education" is the key word for the 1968 Summer Seminar of the Michigan State Medical Assistants Society. This year's Seminar is to be July 20-21 at Boyne Highlands, Harbor Springs, Michigan.

Designed as an annual event for continuing education of medical assistants, the two-day meeting will feature physicians speaking on a variety of subjects. Included will be: Robert I. Goldsmith, M.D., assistant professor, Department of Ophthalmology at the University of Michigan, on "Some Common Misconceptions in Eye Disease."

Paul W. Gikas, M.D., associate professor, Department of Pathology at the University of Michigan, will speak on "The Pathogenesis of Fatal Injuries in Highway Accidents."

"A Working Philippine Vacation, Experiences Unlimited" is the topic of Sidney N. Smock, M.D., Midland anesthesiologist, who will deliver the banquet address on Saturday evening, July 20.

A panel discussion will comprise the Sunday, July 21, program. Speaking on "The Medical Assistant and Office Management" will be R. Timothy Hogan, member of the Board of Directors of Professional Management, Ann Arbor. Marcus L. Plant, J.D., professor, University of Michigan Law School, will discuss "The Medical Assistant and the Law."

"The Medical Assistant and Public Relations" is the topic of Barry H. Alford, M.D., Plymouth, Chairman of the advisory board of the Washtenaw County Medical Assistants and member of the MSMAS Advisory Committee. Winslow G. Fox, M.D., Ann Arbor, Chairman of the MSMS Medicine and Religion Committee will discuss "The Medical Assistant and the Patient with Special Needs."

Chairman of the 1968 Summer Seminar is Mrs. Patricia Austin of Ann Arbor.

Busy H/D Committee Chairmen

The committees of the MSMS House of Delegates are hard at work completing assignments and reports for the September session. The following men have been appointed as chairmen by Speaker James B. Blodgett, M.D.:

COMMITTEE TO RE-EVALUATE THE DUTIES OF THE PRESIDENT – C. Allen Payne, M.D., Grand Rapids

COMMITEE ON MEDICAL STAFF SURVEY OF HOSPITALS – Rosser L. Mainwaring, M.D., Dearborn

COMMITTEE ON CERTIFICATES OF COMMENDATION – Marjorie Peebles-Meyers, M.D., Detroit

COMMITTEE TO SELECT MICHIGAN'S OUTSTANDING PHYSICIAN – D. Bonta Hiscoe, M.D., Lansing

COMMITTEE ON PROCEDURES OF THE HOUSE OF DELEGATES – Noyes L. Avery, Jr., M.D., Grand Rapids

COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE – John G. Slevin, M.D., Grosse Pte. Park

COMMITTEE TO STUDY FINANCIAL STRUCTURE OF MSMS – James D. Fryfogle, M.D., Southfield

UP Medical Event June 21-22

Bradley M. Harris, M.D., MSMS President from Ypsilanti will speak at the Upper Peninsula Medical Society's 75th Annual Meeting at the Four Seasons Club in Pembine, Wisconsin, June 21-22, on "Tomorrow's Doctor."

MSMS Past President, George W. Slagle, M.D., will speak on "The Physician's Role in Use of Health Care Resources."

Ovid O. Meyer, M.D., professor of medicine at the University of Wisconsin, will talk about "Present Day Treatment of Leukemias and Lymphomas," and "Recent Advances in Treatment."

Other speakers are George E. Collentine, Jr., M.D., director of the Burn Center at St. Mary's Hospital in Milwaukee, who will discuss "Emergency Management of Burns;" Ralph L. Suechting, M.D., a neurosurgeon from Neenah, who will speak on "Post Traumatic Head Pain and Neck Pain;" James W. Nellen, M.D., orthopedic surgeon with the Green Bay Packers, whose talk is entitled "Strapping of Common Athletic Injuries;" and Ernest O. Henschel, M.D., professor of anesthesiology at the Marquette School of Medicine, who will talk on "Pre-and Post-Operative Medication."

Registration for the meeting begins at 5 p.m., June 20.

TO INVITE OSTEOPATHS

The Board of Directors of the Oakland County Medical Society recently passed a motion that the society pursue an active program of inviting osteopathic physicians to attend the society meetings.

Aiuto to Lead WSU Alumni

New officers for the Wayne State University School of Medicine Alumni Association were elected at the Centennial Clinic Day and Alumni Reunion in Detroit May 15.

James Aiuto, M.D., Grosse Pointe, took office as president along with Frank B. Walker, II, M.D., Grosse Pointe, and William A. Harrity, M.D., Grosse Pointe, as president-elect and secretary, respectively. Warren O. Nickel, M.D., Dearborn, continues as treasurer.

Elected to the Association's Board of Governors were Doctors James J. Horvath, Grosse Pointe; Charles C. Vincent, Detroit; and David Jacknow, Huntington Woods.

Outgoing president is Mario A. Petrini, M.D., Detroit.

NOW IN VIETNAM

Most recent Michigan physician to leave for Vietnam under the AMA Volunteer Physicians for Vietnam program is Armand M. LaSorsa, M.D., of Manistique. Doctor LaSorsa, a general practitioner, left for South Vietnam in early May and will return in July.

"Formula for Progress Against Cancer" was the focus of a recent MAP TV broadcast by WJIM-TV in East Lansing. From left to right are Hugh Brenneman, MSMS and MAP Executive Director, who hosts the weekly program; Melvin L. Reed, M.D., of Detroit, associate clinical director of the Milton A. Darling Memorial Cancer Center and assistant professor of oncology at Wayne State University; Alan F. Phillips, M.D., of Flint, a radiotherapist at Hurley Hospital; Max E. Dodds, M.D., also from Flint, chairman of the MSMS Cancer Committee; and Helen Menton, producer of the show.

MAP Honors Gross, Nolen

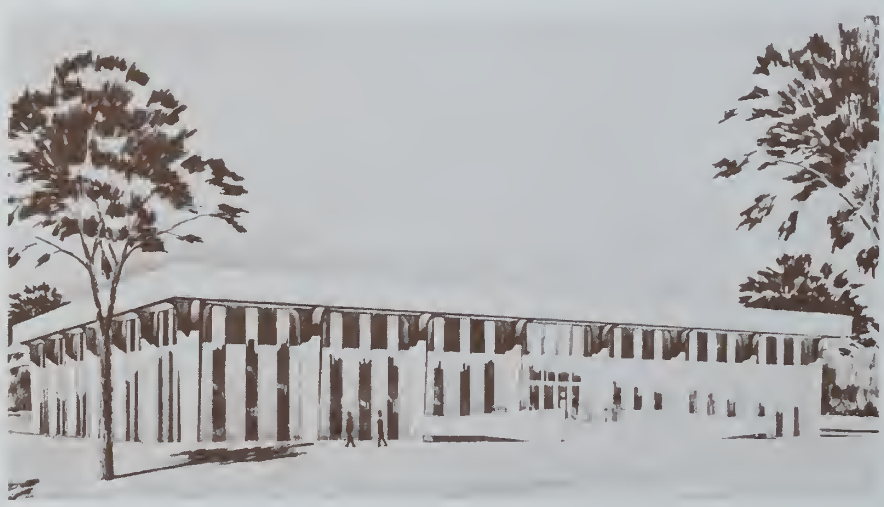
Harold F. Gross, president of Gross Telecasting Company (WJIM-TV and radio in Lansing) received the Outstanding Service Award, and John G. Nolen, D.D.S., of Lansing, received the Distinguished Award during the ninth annual Congress of the Professions, May 10-12 at Boyne Highlands.

The Outstanding Service Award is given annually to "An individual who has rendered greatest service to the professions represented in MAP." The Distinguished Award, also given annually, is for "One member of MAP who has made an outstanding professional contribution."

The Congress continued Luther R. Leader, M.D., Royal Oak, for a two-year term on the MAP board of directors. G. B. Saltonstall, M.D., Charlevoix, and J. Russell Brink, M.D., Grand Rapids, have another year to serve as members of the board. The board will elect officers at its next meeting.

Theme of the Congress this year was "Practical Aspects of the Professional Concept."

(Further details will appear in future issues of *Michigan Medicine.*)



WSU Medical Library Project Proceeds

Ground is scheduled to be broken this year for a $2,000,000 Shiffman Medical Library to be built by the Wayne State University School of Medicine. The project will be financed by a $1,432,246 grant by the Public Health Service of the U. S. Department of Health, Education and Welfare, a $500,000 gift from Abraham Shiffman through the Shiffman Foundation and $200,000 raised by the WSU medical alumni. Part of the alumni contribution will pay for furnishings, equipment and books.

The building will be located on the southwest corner of Brush and Canfield, near the medical school's Research Building and the Basic Science Building now under construction. Both Brush and Canfield will be closed and converted to pedestrian malls when the Medical Center is further developed.

Several physicians have worked to raise contributions for the new library through the Wayne University Medical Library Inc. headed by John Webster, M.D., fund chairman. Officers of the corporation are Drs. Edward M. Vardon, president; Don W. McLean, vice president; William J. Stapleton, Jr., treasurer; J. Courtney Fremont, assistant treasurer and Edgar C. Long, secretary. Alumni Director Homer D. Strong is assistant treasurer and resident agent.

BEEMAN, WILLIS ON HEART FORUM

Carl B. Beeman, M.D., of Grand Rapids, president of the Michigan Heart Association, moderated a public forum called "Hope For Your Heart" on Friday evening, May 10, at Ford Auditorium in Detroit, during the annual meeting of the Michigan Heart Association.

One of the speakers on the panel, co-sponsored by the Detroit *Free Press,* was Park W. Willis, III, M.D., professor of medicine at the University of Michigan Heart Station. Doctor Willis spoke on "Rheumatic Fever; High Blood Pressure."

The Nineteenth Annual Scientific Session of the MHA was well attended May 10-11 at the Rackham Memorial Building. Program participants included Michael C. Kozonis, M.D., Pontiac; Joseph N. Schaeffer, M.D., Detroit, and Henry H. Swain, M.D., Ann Arbor.

HEUSTIS, DANTO SPEAK AT ALMA CONFERENCE

MSMS was co-sponsor of a Physician-Clergy Workshop at Alma College on May 2 for Michigan clergy and physicians.

Physician speakers were Albert E. Heustis, M.D., director of Michigan Regional Medical Program and Bruce L. Danto, M.D., director of the Community Psychiatry Program for the Detroit Psychiatric Institute.

Keynote speaker was Rev. Robert B. Reeves, Jr., chaplain at Columbia-Presbyterian Medical Center in New York City.

DSA Hears Shumway

Over 200 physicians, members of the Detroit Surgical Association, heard Norman F. Shumway, Jr., M.D., who has done two heart transplants, speak on "Transplantation of the Heart," in Detroit on May 8. Doctor Shumway, professor of surgery at the Stanford School of Medicine, spoke at the DSA annual banquet.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

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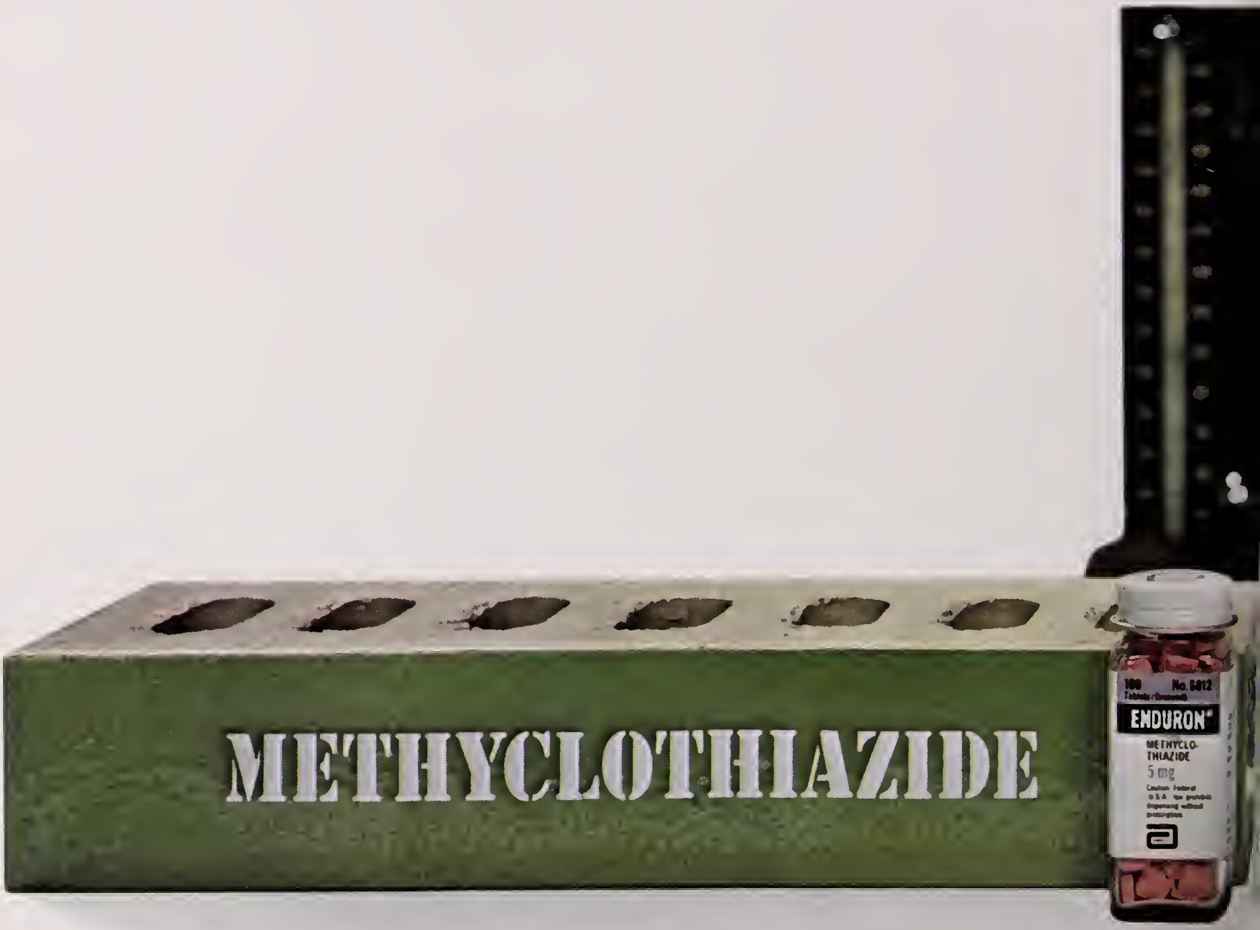
Enduron: (methyclothiazide) A basic building block for mild hypertensives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ENDURON
METHYCLO-THIAZIDE
5 mg

Excellent day-long Na⁺ output, yet easy on the K⁺

Enduron provides an excellent starting therapy. Your patient sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persists for a full 24 hour With Enduron you can prescribe convenient once-a-day dosa without skimping your patients on day-long thiazide effectivenes

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample most cases.

Once a day, every day

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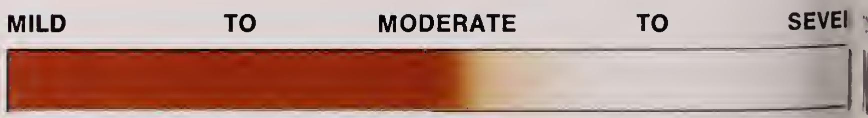
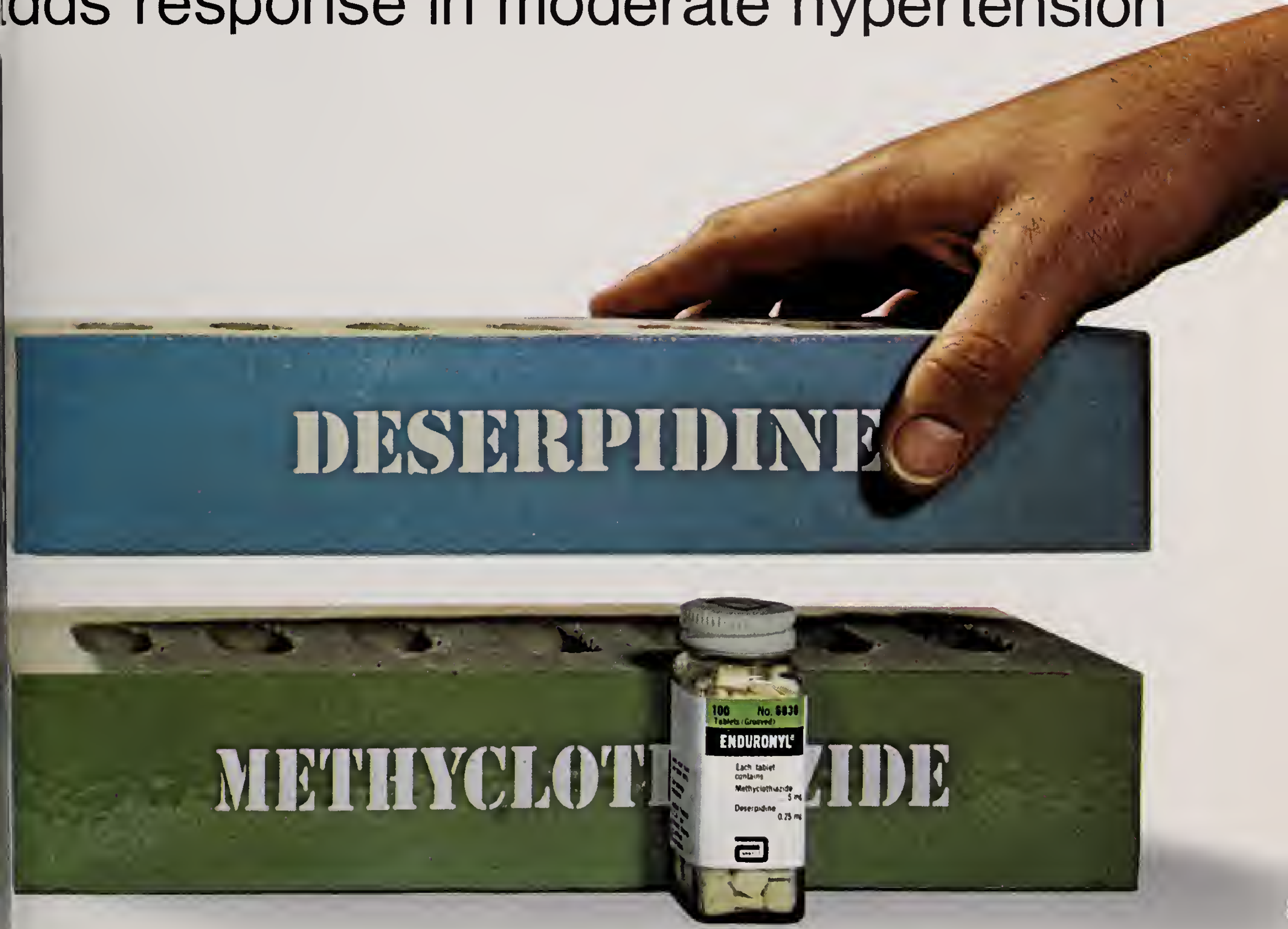

MILD
TO
MODERATE
TO
SEVE

See Brief Summary on final page of advertisement

nduronyl: Its deserpidine component
dds response in moderate hypertension



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100 No. 6830
Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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NDURONYL®

YCLOTHIAZIDE 5 mg. with
PIDINE 0.25 mg. or (FORTE) 0.5 mg.

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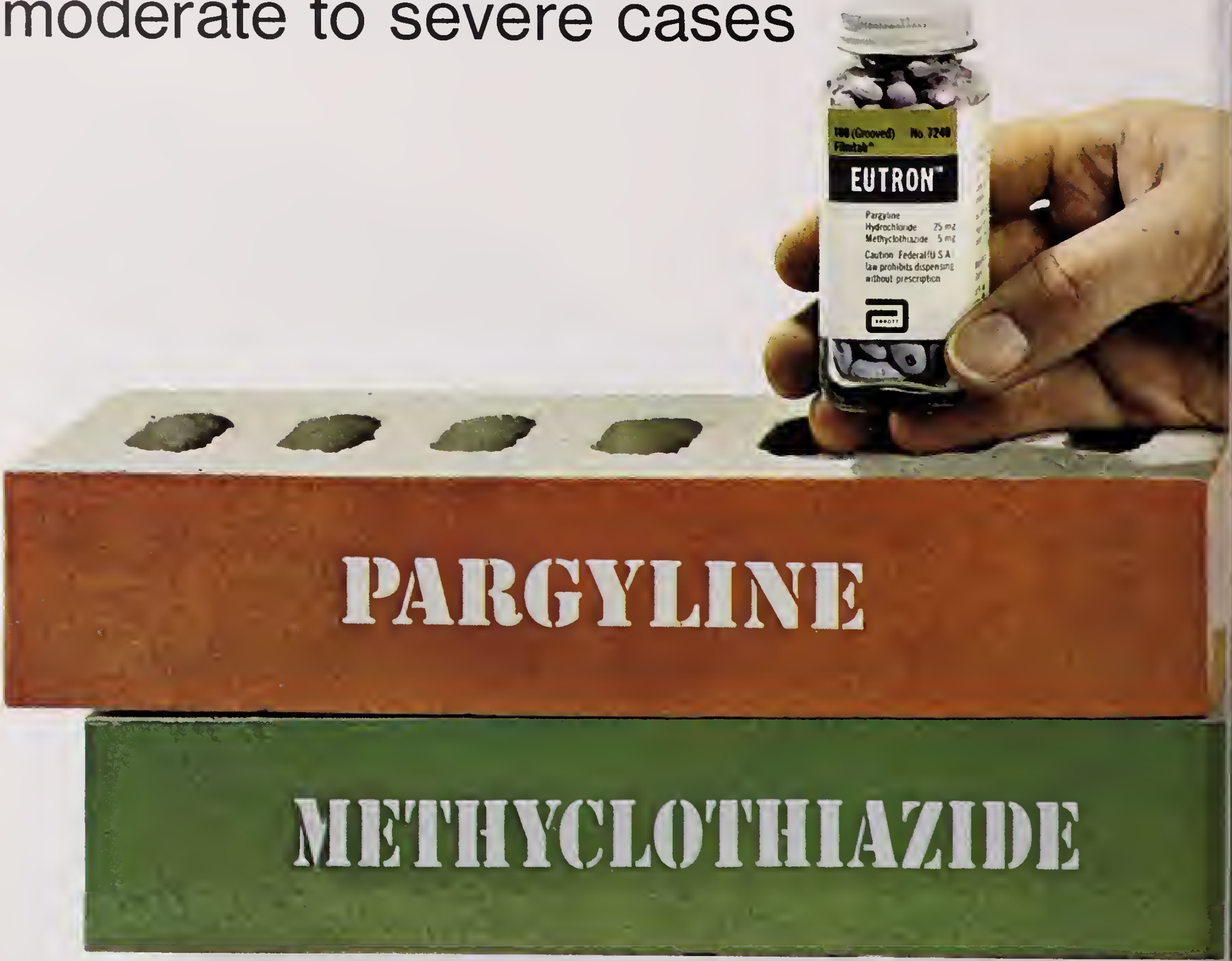
Eutron: A unique combination for handling moderate to severe cases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Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
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METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether yo patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings we reduced from 112 pre-treatment to 90 post-treatment; *sitting* fro 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nea alike in all three body positions.

Use Eutron for managing your moderate to severe cases. building blocks enhance each other; hence lesser doses often suffic

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVE

See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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COMING EVENTS

COLLER-PENBERTHY-THIRLBY EVENT SET AT TRAVERSE IN JULY

All Michigan physicians are invited to participate in the 48th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 25-26.

The excellent program will begin at 9:00 a.m., July 25 and conclude at noon, July 26, according to James W. Hall, M.D., local chairman of the committee on arrangements. He reports that the "fine program has been prepared by A. James French, M.D., University of Michigan Medical School, and his associates."

Michigan physicians who have been selected to speak include Alexander J. Walt, M.D., Clifford D. Benson, M.D., G. Thomas McKean, M.D., T. N. Evans, M.D., all of Detroit; William D. Robinson, M.D., Harold A. Oberman, M.D., Edgar A. Kahn, M.D., Walter P. Work, M.D., Stuart M. Finch, M.D., William J. Oliver, M.D., Arthur C. Curtis, M.D., F. Bruce Fralick, M.D., Robert B. Sweet, M.D., all of Ann Arbor; Allen J. Enelow, M.D., Scott N. Swisher, M.D., both of East Lansing; and Warren W. Cline, M.D., Traverse City.

Out-of-state medical educators will come from California, Ohio, Florida, Missouri, Maryland, Nebraska, Minnesota, Texas, and Illinois.

Further details will appear in future issues of *Michigan Medicine.* ☐

Offer Career Guide

MSMS has inserted eight pages of Michigan information in a new AMA "Horizons Unlimited" career pocketbook for distribution to school counselors, libraries, youth-serving agencies and others who guide and counsel young people. The booklet describes the "Challenge of Medicine" and suggests that there are "vast new medical horizons opening up as the result of promising experiments in transplantations." The booklet is distributed by the MSMS Public Relations Committee. Interested MSMS members may obtain a copy of the booklet for reference use in their reception rooms by writing to MSMS, 120 West Saginaw, East Lansing, 48823.

MICHIGAN MEDISCENE

June 5 — The Council, MSMS Headquarters, East Lansing

June 16-20 — 1968 AMA Annual Convention, San Francisco

June 21-22 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

July 20-21 — MSMAS Summer Seminar, Boyne Highlands, Harbor Springs

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

OFFER NUCLEAR RADIATION DETECTION COURSE AT U-M

An intensive two-week course in Nuclear Rediation Detection for Medical and Health Scientists will be offered for the first time July 8-19 by the University of Michigan College of Engineering. The introductory lecture and laboratory course is designed to provide a working familiarity with devices and techniques used in the measurement of ionizing radiation. Emphasis is placed on the fundamental principles of detector devices, with examples of their application in radiological health, nuclear medicine, radiology, and related fields.

Further information may be obtained by writing to: Engineering Summer Conferences, Chrysler Center, North Campus, The University of Michigan, Ann Arbor 48105. ☐

MSU Museum Seeks Medical Books, Items

Val Barryman, curator of historical artifacts at the Michigan State University Museum, announced recently that the museum is interested in expanding its collection of medical items.

"We are especially interested," Mr. Barryman said, "in medical instruments, medical books and journals, and doctor's personal records, diaries, or photographs prior to 1930."

Physicians who would like to donate such items can write to Mr. Barryman at the Michigan State Museum in East Lansing. ☐

Is it depression?

She says "I'm always on edge..."

...but her other symptoms:
depressed mood, insomnia,
anorexia, feelings of guilt
strongly suggest
an underlying depression.

when the diagnosis is depression

ELAVIL® HCl
AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

ACTIVITIES, PROJECTS

MSMS CANCER COMMITTEE URGES PAP TEST

The MSMS Cancer Committee continues to urge women to have a Pap Test to help reduce the predicted 300 deaths in Michigan from Cervical Cancer.

The Cancer Committee, which estimates that only 18 per cent of the adult women in Michigan have ever had a Pap Test, recently pushed the campaign through the Michigan press. A MSMS News Release was carried by many papers. The following headlines, tipical of many, carried the MSMS message:

Grand Haven Tribune: *"Women Reminded Cancer Tests Needed Yearly"*

Utica Daily Sentinel: *"Simple Pap Cancer Test Prevents Many Needless Deaths of Women"*

Greenville Daily News: *"Women Urged to Get Pap Test"*

Escanaba Daily Press: *"Women Neglecting Cancer Protection"*

Petoskey News-Review: *"Women Must Become Aware of Pap Tests"*

MSMS Health Award Honors State PTA

The Michigan Congress of Parents and Teachers (PTA) recently received an Outstanding Health Service Award from MSMS at the state PTA convention in Battle Creek on the occasion of the organization's 50th Anniversary.

The MSMS citation to the PTA was "for distinguished leadership in Michigan during 50 years of service in helping parents and children study and adopt good health practices," and especially "for current PTA programming in such critical health areas as family life and sex education, smoking and health, and others." The award, presented by George W. Slagle, M.D., Battle Creek, also "pledged the continuing cooperation of Michigan doctors of medicine as consultants and program participants during the next half century in the PTA voluntary approach to further improve the family, school, and community."

Recommended by The MSMS Award Committee, the citation was approved by The MSMS Council.

Left to right, Rep. Warren N. Goemaere, of Roseville, Herbert A. Raskin, M.D., Chairman of MSMS Committee on Alcoholism and Drug Dependence, and Rep. Dale Warner of Eaton Rapids, discuss narcotics legislation pending in the State Capitol. Both State Representatives are members of committees dealing with alcoholism or narcotics and Mr. Warner chairs a special study group in this area.

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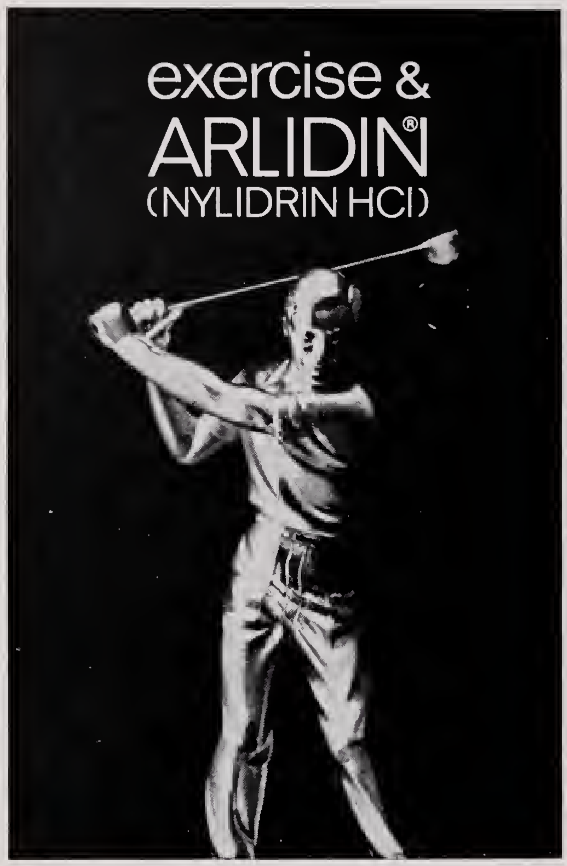

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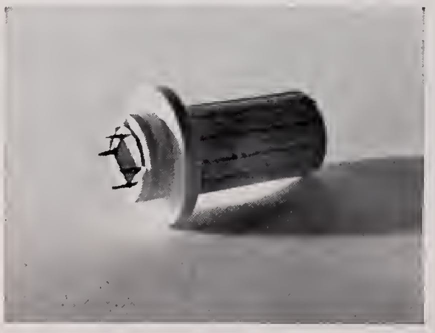

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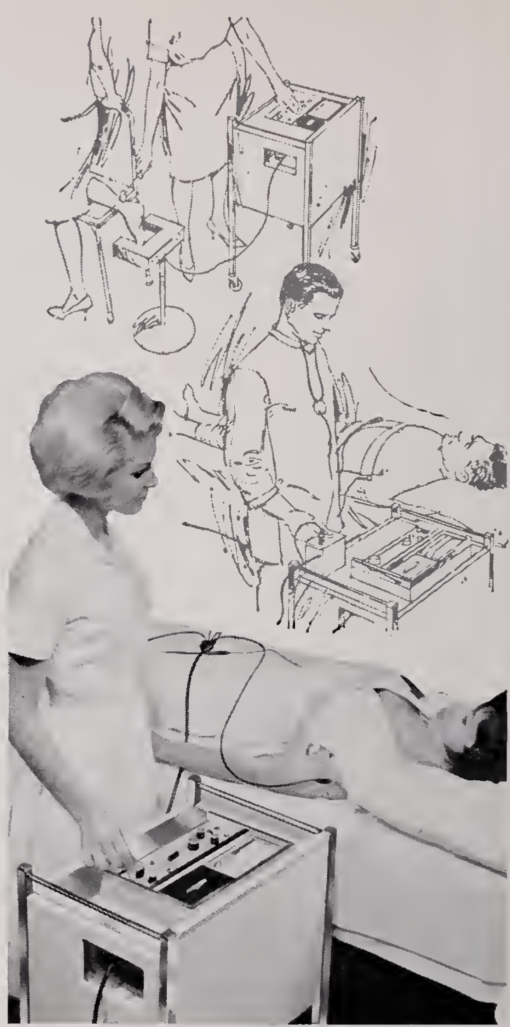

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VIEWPOINTS

Thank You, George; Best Wishes, John

BY BROOKER L. MASTERS, M.D., CHAIRMAN, MSMS PUBLICATION COMMITTEE

This issue of *Michigan Medicine* really has two Scientific Editors as George H. Lowrey, M.D., leaves the post and John W. Moses, M.D., begins his service.

The MSMS Council, at its last meeting, unanimously passed a motion to thank Doctor Lowrey for his outstanding service as the Scientific Editor since April, 1966. He had submitted his resignation because of new responsibilities at the University of Michigan Medical School.

Doctor Lowrey, during his term, provided fine scientific papers for the MSMS membership. Many of these he actively recruited by encouraging physicians to especially develop original scientific articles for *Michigan Medicine*. As a professor of pediatrics at Ann Arbor, he had many contacts with the medical educators; and he had many relationships across the state with practicing physicians through his lectures to county medical societies and hospital staffs.

□ □

The new editor, Doctor Moses is director of medical education at Mt. Carmel Hospital in Detroit and well qualified to serve as the Scientific Editor. He received his medical degree from Boston University and has practiced in Michigan since 1954. He was in private practice until joining Mt. Carmel several years ago.

LOWREY

MOSES

Doctor Moses is an associate editor of the *Detroit Medical News* and has written for many medical publications. He is very active in the Wayne County Medical Society and is one of the WCMS delegates to the MSMS House of Delegates.

The Publication Committee, and The Council, sincerely thank Doctor Lowrey for his contributions to medical postgraduate education in Michigan, and also wish Doctor Moses well as he continues to improve the quality of the scientific articles in *Michigan Medicine.*

The Constant Search

BY MILTON ROUSE, M.D.
AMA PRESIDENT

In all fields of endeavor, there is a never-ending look for new and better ways to nourish man's progress and kindle his hopes for a more perfect existence.

But perhaps nowhere is this endless search more passionate and more meticulously checked and rechecked than in medical science.

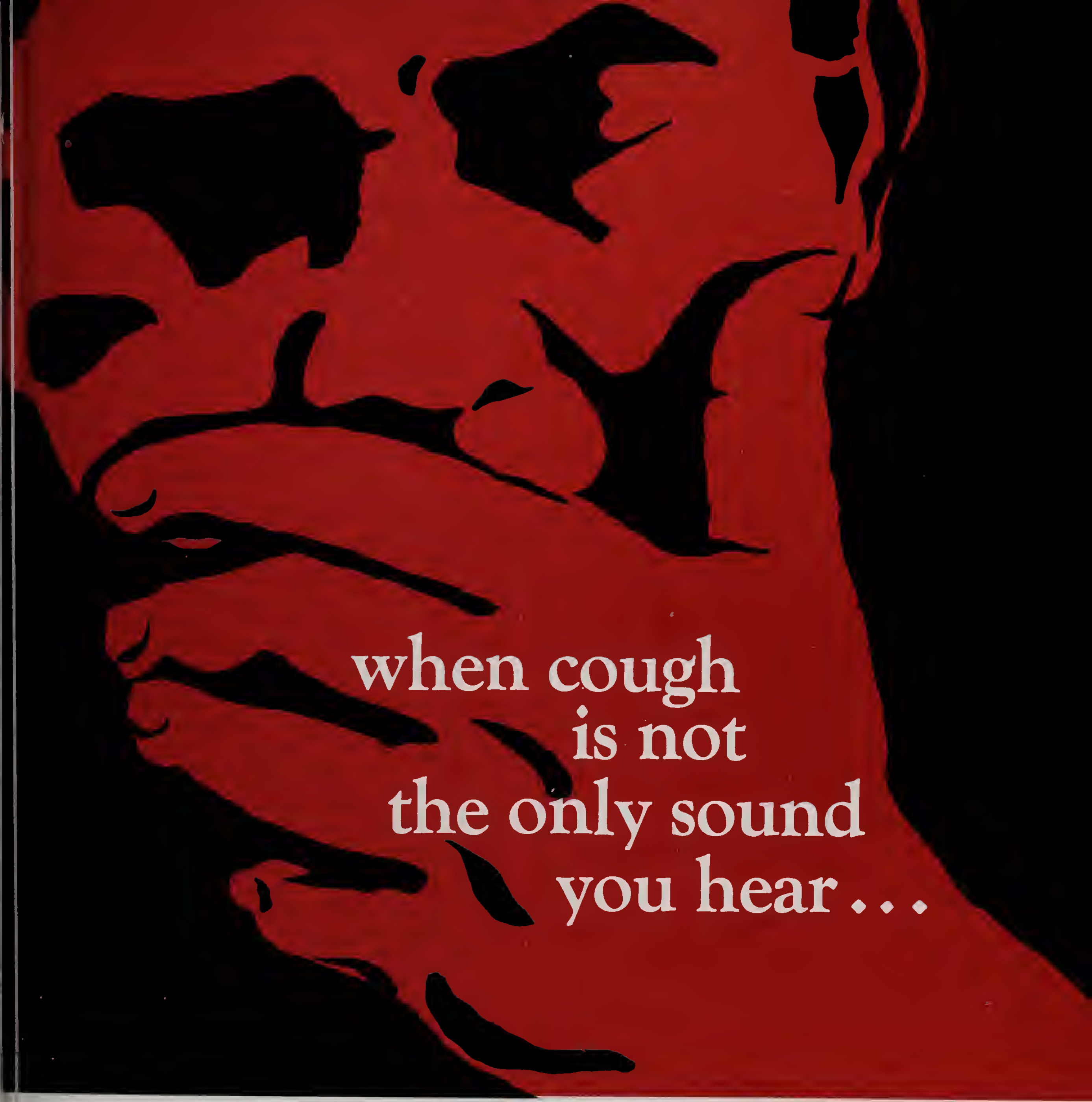
And nowhere are the bounteous fruits of this quest more evident than at the AMA Annual and Clinical Conventions, remarkable scientific spectacles without equal and a living tribute to all who have made personal contributions and sacrifices aimed at furthering the art and science of medicine.

Take the forthcoming 117th Annual Convention in San Francisco June 16-20, for example. This vast panorama of all that is current in every area of medicine will beckon more than 60,000 persons, all of whom will be drawn closer to the heartbeat of medicine and its eternal promise just by being a part of it.

At least 16,000 of them will be physicians taking advantage of a remarkable educational opportunity which will enable them collectively and individually to learn and implement proven methods and techniques destined to further improve the quality of medical care not only for Americans, but for people everywhere.

Indicative of the quality, scope and thoroughness of the Scientific Program in which they will participate is the fact that more than 2,000 men

(Continued on 767)



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1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

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Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with Oracon has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of Oracon usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: Oracon is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on Oracon are available from Mead Johnson Laboratories.

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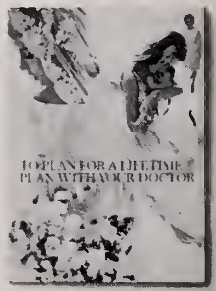

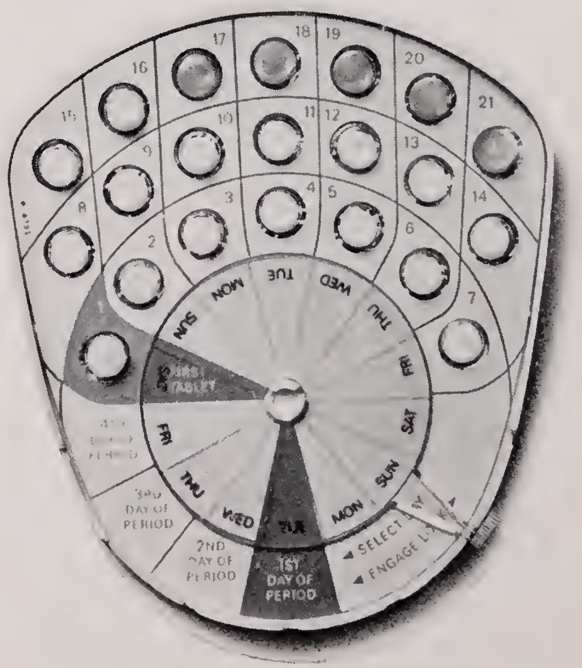

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The Need for Utilization Review

BY LOUIS F. HAYES, M.D.
VICE PRESIDENT
MEDICAL AFFAIRS DIVISION
MICHIGAN MEDICAL SERVICE

"What is Utilization Review?"

The objective of this article will be to provide a simple definition of utilization review. I hope we can make it more explicit than one definition given: "a word of French and Latin derivation, containing 11 letters, whose use in medical circles often causes a vulgar Anglo-Saxon response"; yet I do not want to be as vague as another definition: "striving to reach a goal as yet undescribed, using methods as yet undefined and involving all concerned parties in roles as yet undetermined."

Let's begin with the basic definition of each of these two words. Utilization is "the act of making use of"; review is "to look at again — to look back on — to take a retrospective view." Now let us take a small liberty with these definitions by expanding them a bit to encompass medical services. To do this we need only to add the word "good"; thus our end result is "looking back at making good use of."

To utilize (there's that word again) this definition in terms of health care, we should ask ourselves three questions:

1. What do we look back at?
2. What does it mean?
3. What can we do with the information?

What do we look back at?

To measure utilization of medical services we need only concern ourselves with incidence of services. Tabulation of the frequency of items of all kinds, hospital days, surgical procedures, diagnostic procedures, office and home visits would provide an impressive array of statistics. Another dimension should then be added — patient information, such as age, sex, location and diagnosis. Such items then become the raw material for utilization review.

What does it mean?

Establishing relationships between the above mentioned items would give us patterns of use by environment, profiles of practice by providers and utilization by patient. Interpretation is another matter; the mathematical relationships could be subjected to statistical analysis, but a more significant interpretation requires medical judgment. Only physicians can suggest with relationship, which patterns, which profiles have sufficient medical significance to make them reasonable indicators of medical quantity. And it necessarily follows that only physicians can examine these quantitative factors and draw conclusions relative to the quality of care.

What do we do with the information?

Obviously, information is of little use unless it can be used in a practical manner. Ultimately, utilization statistics should have the function of improving the use of and quality of medical care. To effect this, we delete the word "review" and substitute a more onerous word, "control."

The responsibility for control in the area of quantity belongs to the carrier and the physicians (both inside and outside the carrier structure). When data reveals misuse, the fiscal responsibility of the carrier dictates appropriate action. Detection of over-utilization calls for a joint effort, the carrier in identifying, physicians in correcting.

Control of the quality of medical care is another matter. In this endeavor, the carrier serves

AUTHOR:
HAYES

First in New Series of Articles:

The following article is the first of a series to be prepared for publication in *Michigan Medicine* by the staff of Michigan Medical Service. Future articles will deal with the following topics:

The Need for Utilization Review
Utilization Review Systems-Characteristics and Operation
Measurement of Quality and Quantity of Medical Services
Role of Non-Physician in Utilization Review
Role of Physician in Utilization Review
Michigan Utilization Review Project

primarily an educational function; as the reservoir of raw data and, because of computer capacity, they should be responsible for the preparation of information — they "review." "Control" requires medical judgment and appropriate corrective measures; heavy physician involvement is needed to do this effectively. Since physicians have the right to medical judgment in the quality of medical care, they have also the obligation of correction when poor quality is detected.

The charge will probably be made that I have over-simplified this matter — but I have a compulsion to reduce problems to simple terms. It would seem elemental that the carrier, as the source of data, be responsible for arraying the statistics — and equally fundamental that the physicians are the only ones capable of making judgments on the quality of care. But a more important point is that this should be a mutual endeavor, with divided responsibilities but a common goal — providing the best medical care at the lowest possible cost. □

Health Council, Consumer's Publish Booklet to Help Recruit Doctors to State

The Michigan Health Council, in cooperation with Consumers Power Company of Jackson, is distributing a new brochure designed to attract family physicians to practice medicine in rural areas of Michigan.

The booklet gives large emphasis to the natural beauties of Michigan, the excellent medical facilities in the state and the personal testimony of several Michigan physicians who have found rural practice rewarding.

"I have had more than fifteen years of family practice in a typical small community in Michigan," writes Brooker L. Masters, M.D., of Fremont. "During this time, I have enjoyed a most rewarding professional life, as well as a most desirable community in which to live with my wife and children."

"Not only baby, but parents, grandparents, aunts, and uncles have been an integral part of the mosaic of my life as a family doctor in a small community," says R. W. Spalding, M.D., of Bloomingdale.

"Here, the pace of living has been slow enough to allow time for growing up with my family and, at the same time, be a respected and esteemed member of every other family in the community. A source of great personal satisfaction has been the opportunity to help guide so many lives from babyhood to childhood into the teen years and on through adulthood," Doctor Spalding concludes.

Ten thousand copies of the brochure have been printed and are being distributed throughout the U.S. to physicians who have expressed interest in Michigan as a place to establish practice.

"We also have distributed copies to the medical schools," comments John A. Doherty, Executive Director of the Michigan Health Council. "The booklets will be given to freshmen, sophmore, and junior medical students so that early in their career they will become aware of the great potential in rural medical practice."

Ben N. Saltzman, M.D., A.M.A. Chairman of the Council on Rural Health, also comments in the booklet: "I enjoy knowing people and their families. I like being treated as a member of a family and at the same time held in a position of respect and esteem. My philosophy of life is a simple one–freedom from financial care; good health and adequate educational opportunities for my children; and a position of prestige for my wife and myself in a community. This, in essence, is the recompense for family practice— and what I have enjoyed for 21 years."

"We all enter the field of medicine with personal dedication," Doctor Saltzman concludes. "Through rural family practice in an uncomplicated, straight-forward and appreciative environment, I have realized the fulfillment of those early dreams." □

When it's more than a bad cold

your patient can feel better
while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

350-8

...progress in protection

Blue Shield's new Variable Fee and Extended Benefits program protects both patients *and* physicians against the unpredictabilities of fluctuating costs. A progressive movement in voluntary prepayment plans, the new program will need your support.

Remember, as a Blue Shield participating physician, you're serving the best interests of your patients *and* yourself.

MICHIGAN BLUE SHIELD

A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

What Is Current Thrust of MSMS In Areas of National, International Affairs?

Where does MSMS stand regarding national and international affairs?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?"

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS. The November, 1967 issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed any of the previous articles may wish to go back and read them. The following article is Chapter IX in the booklet. Copies are available from MSMS, 120 West Saginaw, East Lansing 48823.

Discussion

International Health

This is perhaps the weakest area of MSMS participation. Only in the past year or so has it had a Committee on International Health.

Need in Vietnam

That committee has determined that there is great need in Vietnam for medical aid, particularly if the United States is to reap any reward for its military action there. It will emphasize international health at the MSMS Annual Session.

MSMS Members Serve

Almost by contrast with MSMS as an organization, its members have been extremely active. Michigan doctors have led the nation in percentage of service contribution to Project HOPE, Partners of the Alliance, South Vietnam service, and as medical missionaries abroad.

Doctor Diplomacy

MSMS Participation in Foreign Affairs

Experts on foreign affairs have repeatedly pointed to the fact that doctors working in foreign countries have created more good will than any other "diplomacy" of this nation. These doctors must come from the private sector if they are to be most effective. MSMS has responsibilities as a member of society and a "corporate citizen" of the United States to participate in foreign affairs, particularly when it is recognized that Michigan business, industry, and transportation are now becoming major factors in foreign trade.

Opportunity for Leadership in AMA

Obviously, in many instances the AMA is the proper organization to work through, but a great opportunity exists in that organization for MSMS to give leadership in this field.

Questions

Michigan Partners of the Alliance Belize

A. What part should MSMS play in the medical care of the people of any foreign nation? Belize, as Michigan Partner in Partners of the Alliance for Progress?

World Peace

B. Does MSMS have any responsibility for maintaining world peace by assisting in developing friendly relations with neighbor nations?

Organized Foreign Medical Assistance

C. Should MSMS take an active role in national and international relationships with such organized efforts as the Partners of the Alliance, Project HOPE ship, AMA international physician placement service, etc.?

Recognition of Service

D. Should MSMS honor, individually, its members who are serving now
  1. In the armed forces?
  2. As medical missionaries?
  3. On the HOPE ship?
  4. In the AMA Viet Nam project?
  5. Etc.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

FOR THE FOUR-WEEK PERIOD ENDING APRIL 26, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	36	143	157	641
Whooping Cough	54	105	186	385
Diphtheria	0	0	0	0
Mumps	2079	2195	9376	8133
Scarlet Fever & Strep Sore Throat	1006	1451	5104	7071
Tetanus	0	0	1	0
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	149	121	610	746
Salmonellosis (Other than S. typhi)	39	32	205	182
Typhoid Fever (S. typhi)	0	3	0	4
Shigellosis	22	35	71	155
Aseptic Meningitis	2	2	20	6
Encephalitis	3	9	31	33
Meningococcic Meningitis	7	11	37	25
Influenzal Meningitis	5	4	19	13
Tuberculosis	233	261	997	1054
Syphilis	496	435	1912	2047
Gonorrhea	1386	1252	5547	5282

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!

That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg.
10 mg.
15 mg.

For patients who can't take plain amphetamine

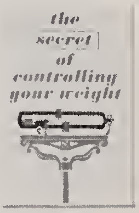
DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444

To help you control your weight...

lease see Brief Summary
next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

Should State Support Osteopathic College?

THIS EDITORIAL APPEARED IN ANN ARBOR NEWS

There is every good reason for the state to proceed slowly with plans to support a college of osteopathic medicine.

Affiliation of an osteopathic institution with one of the state-supported universities is practically a prerequisite, but the schools with established medical colleges don't want an osteopathy program — at least not very badly.

The two disciplines — osteopathy and the traditional MD-granting medicine — barely coexist. But an osteopathic college with state support and university control is a maverick institution supporting itself on dribbles of federal aid, citizen contributions and money from the D.O.'s (Doctors of Osteopathy) themselves.

But with one new medical school (Michigan State University) being funded from scratch and other needs in medicine requiring urgent attention, a $10 million outlay for a college of osteopathic medicine cannot be justified economically.

What kind of prospective medical student is attracted to osteopathy, for example, and how many of this type of student are there out of, say, every 20 medical students? The state just isn't ready, in our estimation, to endow a small and controversial "branch" of medicine with a college of its own. ☐

THREE PHYSICIANS SERVE ON KIEFER CENTER BOARD

John Lumpkin, M.D., from the Detroit Medical Society, A. H. Hirschfeld, M.D., from Wayne County Medical Society, and James J. McClendon, M.D., president of the Detroit Board of Health, will serve on a 15-member board which will direct the Comprehensive Health Services Center, Inc.

Funded by a $2 million Federal grant and located at Herman Kiefer hospital, the health center will serve approximately 33,000 disadvantaged residents in the center of Detroit. Members of the Board of Directors represent various professional health organizations, the Detroit Health Department, the Mayor's Committee for Human Resources Development, and residents of the area to be served by the Health Center. ☐

RECEIVES ENURESIS AWARD

Barbara Starfield, M.D., of Johns Hopkins Hospital, has been named recipient of the 1967 Award of the Enuresis Foundation. James C. Breneman, M.D., Galesburg, president of the Foundation, said the award is presented annually "to the person thought to have contributed significantly to the knowledge and understanding of enuresis and its related afflictions." ☐

Say you saw it in Michigan Medicine

Voluntary Associations And the American Society

BY C. T. HARDWICK, Ph.D.
MSMS ECONOMIC CONSULTANT

Nature of Issue

In contemporary American society, we often contrast the private sector versus the public sector. In general everybody knows the government is on one side and free enterprise consisting of business and professions on the other side. Of course, in reality these opposing forces are compelled into cooperative ventures for total action. However, there seems to be a large organized force also present in current America which should be identified as the *voluntary associations.*

These free associations generally belong to the private sector, but for practical reasons a separate identification seems necessary.

Voluntary associations means an *organization of equals* which is composed of members who *join of free will* for common group purposes.

Some writers call these *mutual-benefit* organizations and examples would include professional associations, fraternal groups, unions, trade groups, clubs, veterans' groups, neighborhood groups and religious sects. Often these organizations are popularly called service groups with private and public interests. Often members are rallied around specific "causes." The organizers attempt to verbalize in idealistic terms the objectives and work of the association for the mutual benefit of members and society in general.

Of course the Michigan State Medical Society would be a prime example of a voluntary association. Individuals acting alone feel weak, but when joined together have strength and power.

IT MUST BE NOTED that voluntary associations are founded and also flourish in an open free society such as current days of progressive America. In a free society, it is part of our heritage and a principle of staying free to encourage the voluntary joining together of a few, or several or many citizens to promote or to fight any cause as they see fit, that is, it is natural for independent citizens to join forces as they please to combat or support government or other organized efforts. Obviously, as recorded history proves, the authoritarian or dictatorship can not and does not permit such freedom for voluntary associations. Hitler and Mussolini abolished and prohibited such mutual-benefit associations which would be expected to fight the monolithic government.

To satisfy the urge of their citizens the dictators usually organized "front" or government sponsored organizations to speak for voluntary groups.

Therefore, it seems essential to know and understand better the role of voluntary associations in the American society. We are fortunate that our natural inclination to form independent associations is permitted and even encouraged as a right of free citizens. Furthermore, a deeper understanding may assist in making voluntary associations more effective and constructive in furthering the well-being of a democratic society.

Growth and Organization

At the initial stages, a few enterprising individuals see the need and potentiality of joining forces with their fellow associates in forming a new organization. This leadership group then issues an invitation to a limited membership with the aim to organize a core action group.

Next, some idealistic and general objectives are identified such as educational, promotional, public relations and representative of delineated viewpoint. Then a broadcast for qualified members is issued and an organizing meeting will be called. Officers are elected and a program of action planned for the coming year. More and more members will be attracted and held if some crisis issue can be found and formulated. The cycle of electing officers and planning programs will have to be repeated for ensuing years.

Then the issues will become more critical or the membership will enlarge or the program will grow to ambitious heights and a reorganization will be stimulated. During the early formative years, all officers, leaders and workers will be part-time volunteers without much remuneration for efforts; thus their time, energy and attention will also be limited.

The increasing demands for more active programs require the employment of some full-time staff.

AT THE TIME OF hiring a full-time staff, some new division of labor will be necessary. The hired employees must assume the handling of routine daily business and the "back up" work for leaders and members. However, the voluntary leaders are still responsible for goals, policies, direction and control of organization.

Now the organization is ready for action at the matured stage of development. Old, routine programs will have to be up-graded; new programs launched and activities enlarged on a broader front.

Leadership and staff will have to analyze programs to determine which ones are merely routine and defensive. With the help of full-time staff, more programs of a constructive, positive and aggressive nature will have to be organized and supported.

In other words, programs will be conducted on two levels. For the short run, some practical service programs should be organized so as to involve as many solid members as practicable.

FOR THE LONG run, some bold and free-wheeling programs are desirable to influence the future direction of the association. These latter programs should be attractive to the younger and avant-garde members.

Since the financial resources of voluntary associations are very limited, usually membership dues are inadequate to support unlimited activities. Thus, each year the activities of staff, committees and programs have to be reviewed and evaluated as to annual contributions. A strict budgetary process will help at this stage of appraisal.

Critical Issues for Associations

In a free society, voluntary associations have strong reasons for growth and survival. As long as leaders and members have purposes and programs satisfying their personal and professional needs, the voluntary association will grow and prosper until government or social forces mount an offensive against them. The attack by government is not expected as long as free enterprise is popular.

THE QUESTION OF "other social forces" will be a challenge to every voluntary association. Unless the association satisfies members, other associations may be formed in a dynamic society. Therefore, independent associations have to be sensitive to readjustments in order to meet changing social needs. Generally voluntary associations have to meet selfish demands of members and still serve the general public.

The voluntary associations prosper on two fronts: namely, routine services to members and the handling of a crisis situation.

Repeated crises tend to solidify membership and leadership has a special problem of keeping up interest with members during ordinary and dull periods. Thus, the leaders have to develop foresight and stimulate interest in future issues. Every year the programs have to have some focus on critical issues to hold and attract interest and attention.

The acid test of the voluntary association in modern America will be settled at the local meeting centered on the questions:

(a) *Do we have a special purpose for existence?*

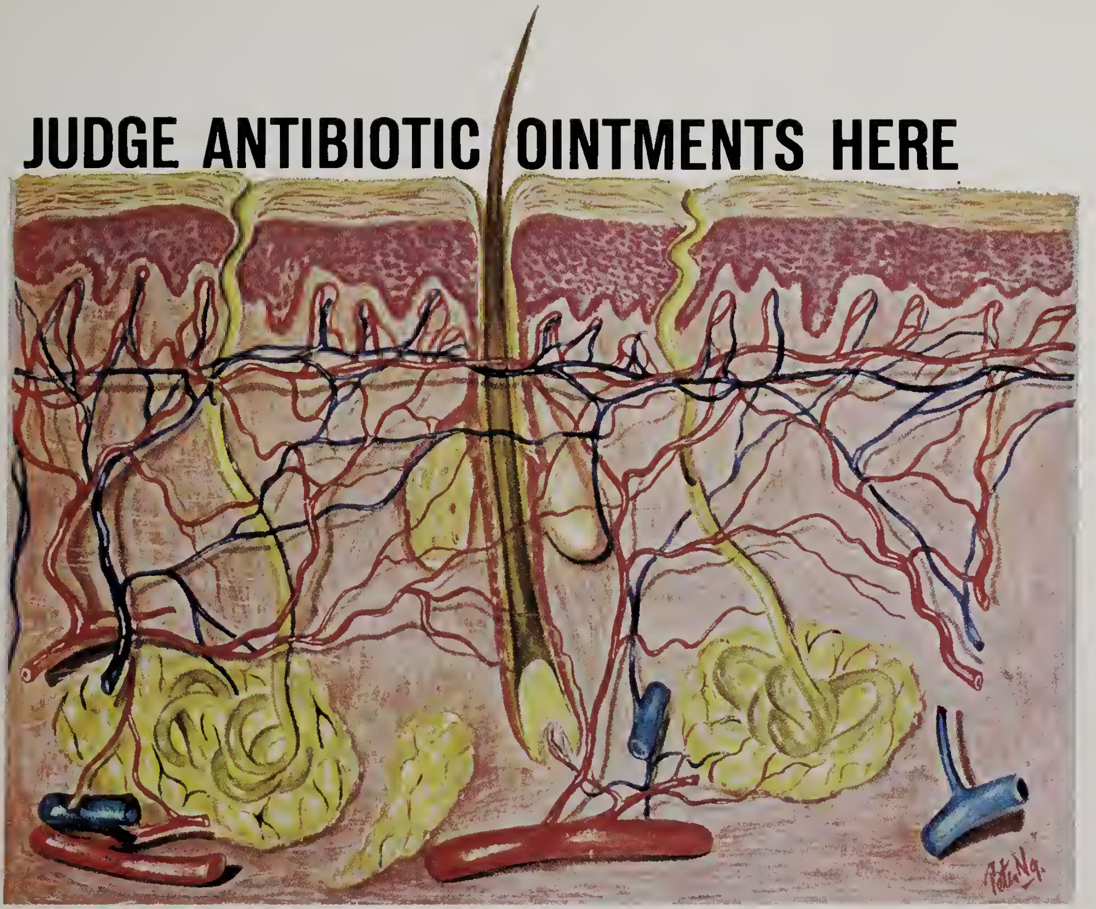
(b) *Is our organization the best means for accomplishing these purposes?*

In conclusion, the future for voluntary associations in America looks very bright and prosperous as long as we can answer a very strong *yes* to both of the foregoing questions. Therefore, the leadership group has to take immediate steps to keep their organizations alert to their responsibilities and opportunities to contribute constructively to the growth of our free society. If the independent organizations do not respond to this challenge, we have only ourselves to blame.

AUTHOR

Doctor Hardwick is Economic Consultant to the Michigan State Medical Society and Associate Dean, school of business, University of Detroit.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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POLYMYXIN B-BACITRACIN-NEOMYCIN

OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

New

Tegretol®
carbamazepine

Therapeutic breakthrough in non-narcotic control of the pain of

trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent
laboratory and clinical evaluations. Should this trend continue, the
should be discontinued.
2. Liver function tests must be performed at regular intervals durin
ment with this drug since liver damage may occur during therapy.
drug should be discontinued immediately in cases of aggravated li
dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and t
etry, are recommended for patients being treated with this drug si
many phenothiazines and related drugs have been shown to cause
changes.
4. Complete urinalysis and BUN should be done on patients treate
Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the fee
nausea, vomiting, aplastic anemia, transitory leukopenia, agranuloc
eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormaliti
liver function tests, cholestatic and hepatocellular jaundice, urinary
quency, acute urinary retention, oliguria with elevated blood pressu
albuminuria, glycosuria, elevated BUN, microscopic deposits in the
impotence, disturbances of coordination, confusion, headache, fati
blurred vision, transient diplopia and oculomotor disturbances, spe
disturbances, abnormal involuntary movements, peripheral neuritis
paresthesias, depression with agitation, talkativeness, nystagmus, ti
nitus, paralysis and other symptoms of cerebral arterial insufficienc
pruritic and erythematous rashes, urticaria, Stevens-Johnson syndr
photosensitivity reactions, alterations in skin pigmentation, exfoliati
dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, e
multiforme and nodosum, aggravation of disseminated lupus erythe
tosus, gastric distress, abdominal pain, diarrhea, constipation, ano
dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills
adenopathy, lymphadenopathy, aching joints and muscles, leg cram
conjunctivitis, left ventricular failure, aggravation of hypertension, h
tension, syncope and collapse, edema, aggravation of coronary arte
disease and congestive heart failure. (Whether these cardiovascula
are drug-related is not known. However, some of these complicatio
resulted in fatalities.) The necessity for discontinuing the drug shou
dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with
if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, th
should be increased in one-half tablet (100 mg.) increments every 1
until freedom from pain is achieved. To relieve pain, between 200 m
1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patie
with a dose of 400 mg. to 800 mg. daily. Maintenance doses may ra
between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts shou
made to discontinue the drug or to reduce the dose to the minimum
effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottl
of 100 and 1000. (B)46-82
For complete details, please see Prescribing Information.

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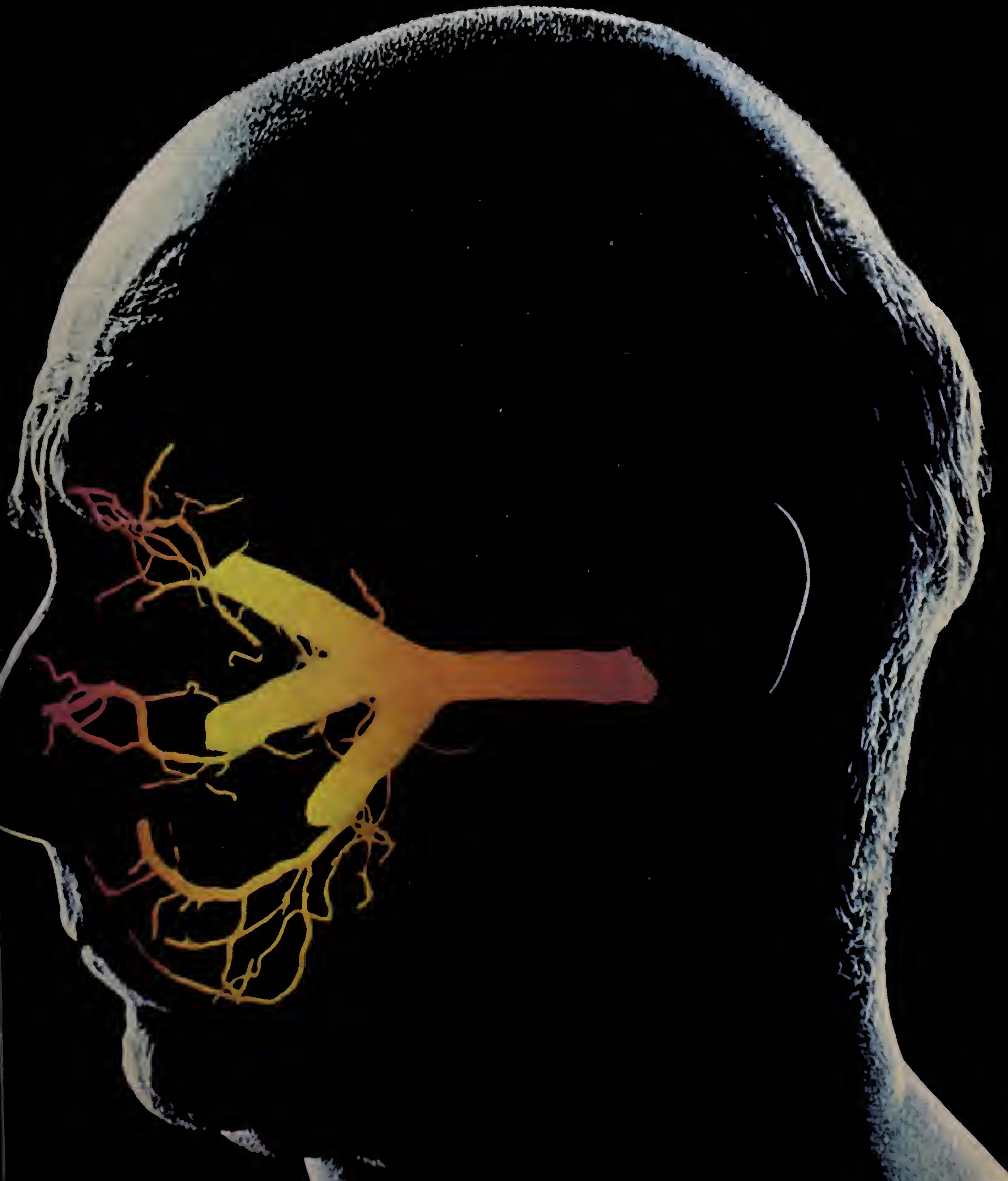

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when you want to provide the combined benefits of two accepted agents in the treatment of mild to moderate hypertension. **(Contraindications: history of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.)**

when you want to prescribe therapy that is generally well tolerated.
(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. **(One tablet a day usually costs about a dime.)**

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

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Blue Shield Reports On Participation, Other Current Programs

BY MICHIGAN BLUE SHIELD

The Michigan Blue Shield report to The MSMS Council in April highlighted a number of topics of continuing mutual interest, of which the Participation Program remains of concern.

Participation Program

While participation agreements are increasing overall in every category, this five-month old program reveals definite trends which, although encouraging, are by no means entirely satisfactory. (See chart below).

Blue Shield's goal is 80% participation by the end of 1968.

In terms of specialty reaction to the Variable Fee Program on the part of doctors of medicine, a breakdown of current participation by generalist-specialist categories is revealing.

Current Physician Participation by Categories

81%	Pathology
81%	Pulmonary disease
81%	Preventative medicine
78%	General Practice
74%	Physical medicine and rehabilitation
72%	Radiology
70%	Dermatology
64%	Cardiovascular disease
59%	Ophthalmology
57%	Neurology
56%	General surgery
55%	Internal medicine
55%	Psychiatry
54%	Otorhinolaryngology
53%	Gastroenterology
51%	Unknown
50%	Allergy
50%	Orthopedic surgery
47%	Obstetrics and gynecology
44%	Neurological surgery
39%	Urology
36%	Anesthesiology
36%	Thoracic surgery
28%	Proctology
18%	Plastic surgery

The participation agreement constitutes the primary, tangible difference between Blue Shield and the insurance companies. Historically, because of its special relationship with the medical profession, the concept of "service benefits" has been a unique quality with respect to Blue Shield. Formal participation, which underlies the whole concept of "service benefits," is necessary if the Variable Fee Program is to maintain Blue Shield superiority.

Variable Fee Administration

Blue Shield has made a number of studies of physicians' fees based on the customary charges reported for Medicare patients and is now engaged in a broader study of the costs of medical care in Michigan.

Since February, 1967, accumulated data involving current charge patterns for a 12-month period have been processed by computer in three separate studies. These studies are insufficient for drawing any final conclusions.

When statistics from a 2-year experience are available, in February, 1969, conclusive studies will be made.

Utilization Review Research Project

This project has moved into an operational phase and is now fully staffed. The Utilization Review Medical Advisory Committee has made suggestions for patterns, profiles and special projects and three important activities are now under way:

1. PILOT STUDY, to determine the feasibility of accumulating a research tape on a subscriber or user basis, and to estimate costs of undertaking a demographic survey for addition to this tape;

2. RESEARCH TAPE, to build which both analysis and programming are now in progress;

3. HISTORY TAPE, featuring selected data being extracted from computer tape files dating from 1959 to 1967. This data will serve as a source of information for reports on past profiles and patterns and will provide a basis of comparison for future studies.

New DSR and Plastic Identification Cards

Blue Shield's claims handling volume is expected to increase from the present level of six million claims annually to more than thirty million within a few years. Among steps taken to prepare for this growth, the new Doctor's Service Report and development of an all-new plastic ID card are expected to simplify both reporting of claims and claims processing.

The new DSR, which will be distributed in

Category	Percentage of Participation December, 1967	April, 1968	Participation Totals	Total Doctors of Record April, 1968
M.D.	60.6%	63.0%	4757	7587
D.O.	44.0%	71.0%	1267	1790
D.S.C.	12.0%	73.0%	188	258
Total	56.4%	63.9%	6212	9635

June, eliminates the need for the patient's signature and involves reporting by code only. The embossed, plastic ID card for imprinter use, which will be introduced early in 1969, will make it possible to transfer all pertinent subscriber information directly to the reporting form. A separate report on this will be furnished to *Michigan Medicine* before implementation.

Both projects should greatly reduce the possibility of transposition errors on the reporting form and help to speed claims processing. □

Taxes Taking More And More of Person's Income in Michigan

BY ELMER WHITE
EXECUTIVE SECRETARY
MICHIGAN PRESS ASSOCIATION

Revenue from state and local taxes increased 96% over the decade 1957-67, the Michigan Department of Revenue reports. Over the same period, personal income reflected only a 67% increase in additional dollars.

Tax dollars collected from local property taxes increased 82%, but local income taxes levied by six Michigan cities pushed the figure to 92% over 1957 tax revenues.

State taxes show an even greater increase: 99% more revenue is flowing into Lansing from state-levied taxes than 10 years ago. Federal taxes from Michigan residents are bringing in about 65% more revenue than in 1957.

Each tax dollar is now divided into 79.29c for the Federal government, 11.52c for the state and 9.19c for local governments.

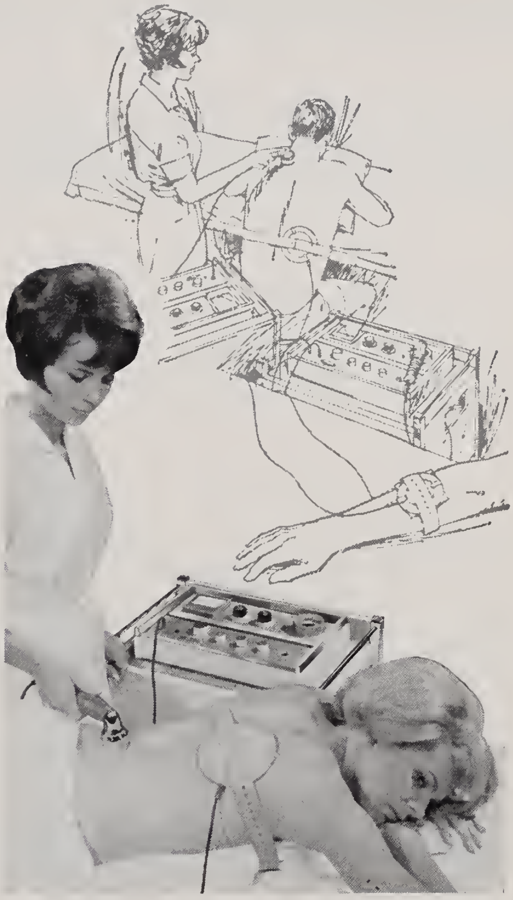
No matter how one views the figures, the conclusion is the same: taxes are taking a larger percentage from personal income every year. To the taxpayer it may make little difference which units of government get the spoils. He is left with fewer dollars to spend.

Yet, unless demands for government services decrease, it is doubtful that the trend to higher taxes will reverse itself.

(Editor's Note: This article appeared in a recent "Michigan Mirror" column written by Mr. White for Michigan newspapers) □

REPRINTS DISTRIBUTED OF UCER ARTICLE

Sandoz Company ordered 19,000 reprints of the article by Erol Ucer, M.D., Lapeer, on "Chlorpromazine and Thioridazine In Severe Mental Deficiency," which appeared in the March, 1968 issue of *Michigan Medicine*. □



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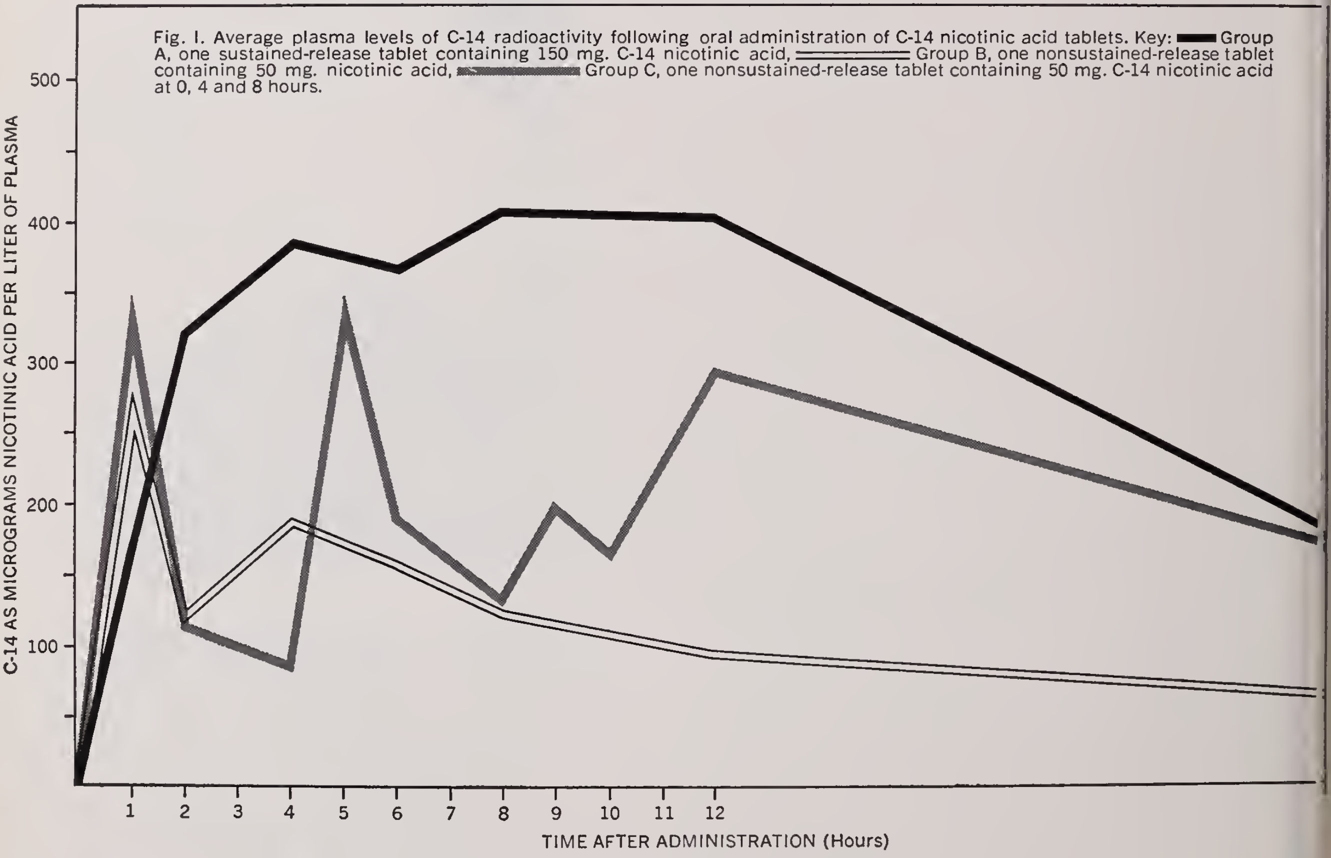

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be c tinuous on a daily dose of only one Geroniazol TT t let every 12 hours.

The gradual release of nicotinic acid in Geroni ol TT will provide the well-known peripheral vasodil tion needed in patients with deficient circulation d with a minimum amount (if any) of "flushing." A o, cerebrovascular circulation is complemented by n-tylenetetrazol, long-established as a cerebral and s-piratory stimulant.

Geroniazol TT improves the typical, unfortun e, signs of senile confusion. Patients become more al t,

ged and debilitated

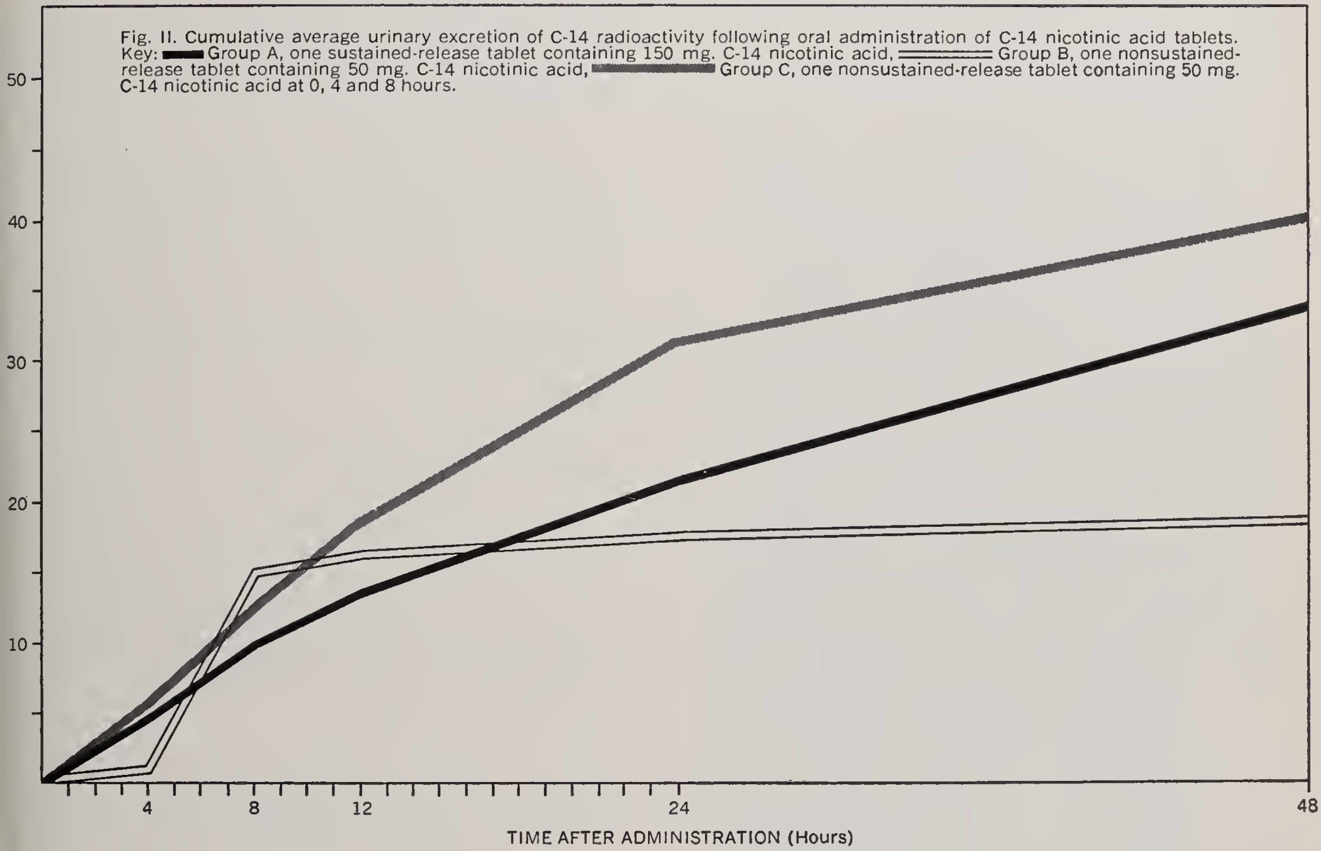

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ss confused and moody. Personal care, memory, notional stability, social attention improve. Fatigue, oathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, an economical price. Dosage is only one tablet every hours.

ontraindications: There are no known contraindicaons.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Work of Detroit Youth Commission in Health Is Explained

BY PETER HOHEISEL
OF THE MSMS STAFF

Several physicians are serving with the Detroit Commission on Children and Youth in several areas of activity with medical implications.

Among the members of the Commission, which is an agency of the City of Detroit and a cooperative agency with United Community Services, is Peter Beckett, M.D., of Lafayette Clinic.

Serving on the Advisory Committee is John J. Hanlon, M.D., Detroit Department of Health Commissioner. Both the Mental Health Committee and the Physical Health Committee have several physician members.

MENTAL HEALTH COMMITTEE

The Mental Health Committee is chaired by Richard Komisaruk, M.D., Director of the Clinic for Child Study. Other members are Lawrence E. Jackson, M.D., Director of the Children's Emergency Psychiatric Clinic at Herman Kiefer Hospital, Peter Beckett, M.D., Sander Breiner, M.D., Thomas A. Petty, M.D., and Lawrence P. Tourkow, M.D.

One of the activities was to work for the establishment of an emergency psychiatric clinic for children at Herman Kiefer Hospital. Financed initially by a $300,000 grant from the city and from United Community Services, the Clinic now is funded by the city and state. It has inpatient facilities for 20 youngsters, and provides several other services including a day care program and outpatient psychiatric care.

In the area of legislation, the committee, in conjunction with the State Department of Social Services, has recommended that the child abuse reporting law be amended in several ways. Among them are:

a) Eliminate the requirement for medical examination in the reporting of suspected cases of abuse.

b) Expand the function of the State Department of Social Services to include the responsibility for arranging a mandatory medical examination as part of its investigation in each case of suspected abuse reported to it, regardless of the extent of injury.

c) The physician's report be separated from the form on which the suspected abuse is reported and that it only contain an objective description of the child's condition and injuries.

d) Reword the law so that a non-medical person who initially observes the abuse is more clearly afforded identical immunity to that of the physician.

e) Provide the State Department of Social Services with the authority to assume payment for medical examination in such cases when the examination is arranged for by the Department and when the examination is secured by the observer, but the parents are unable to pay for it.

In cooperation with UCS, the committee published a fact sheet for reporting actual or suspected cases of child abuse in Detroit and Wayne County.

At present the Mental Health Committee is working to make the child abuse reporting law more effective.

Another project was to gather statistics on the incidence of suicide and suicide attempts by young people.

PHYSICAL HEALTH COMMITTEE

The Physical Health Committee has been especially active in the field of recruiting young people into health careers and up-grading sex education courses in schools.

Serving on the committee are C. Dale Barrett, M.D., Executive Director of PRECAD, and Margaret Zolliker, M.D., Director of the Maternal and Child Health at Herman Kiefer Hospital.

This past spring, about 200 selected students from Detroit public and parochial schools took part in a "Health Careers for Youth" program at Mercy College. They toured the Health Careers Mobile, heard Louis F. Hayes, M.D., discuss career opportunities, watched the new AMA film "Horizons Unlimited," and talked with counselors about the field of health careers.

In the field of sex education, the Physical Health Committee was active in establishing the Detroit Sex Education and Information Council. Richard Komisarvk, M.D., Calier Worrell, M.D., and Everal Wakeman, M.D., are members of this Council and taking an active role in community education and in exchange of materials pertinent to sex education.

The committee has also been concerned about revising the Michigan sex education law.

Roberta Hughes is the executive director of the Detroit Commission on Children and Youth.

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Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
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MSMS Seeks To Improve Performance Of Medical Assistants

BY PHYLLIS MARQUARDT, CMA,
KALAMAZOO; CHAIRMAN,
MSMAS PUBLIC RELATIONS

"Education is the knowledge of how to use the whole of oneself. Many men use but one or two faculties out of the score with which they are endowed. A man is educated who knows how to make a tool of every faculty—how to open it, how to keep it sharp, and how to apply it to all practical purposes." —*H. W. Beecher*

One of the most important objectives of the Michigan State Medical Assistants Society is to "render educational services for self-improvement to its members."

In turn this improvement is reflected to their employers by their increased value to him. Because of this many doctors not only urge their medical assistants to become active in the group, but subsidize the membership for their employees. What is practically impossible to accomplish individually can be accomplished by pooling the thinking of many. It is the same with the American Association of Medical Assistants.

It has been said many times that the only real justification for an organization such as MSMAS and AAMA is improvement in the medical assistants' performance on the job.

SINCE MSMAS WAS organized (1949) each county chapter has had its education chairman who arranged special programs, both formal and informal, in which the members could participate. Speakers at the monthly meetings are chosen for the scientific and educational stimulus they can bring to the members. The exchange of ideas and suggestions among the members is also a part of the educational program. All of these ideas are as important today as they were when we felt the need for an organization such as ours. However, as the practice of medicine becomes more and more specialized and more physicians are forming "group practice," the educational needs of the medical assistant could not be met in these ways alone.

MSMAS was a forerunner in preparing an inservice training program with the cooperation of the Michigan State Medical Society and the Extension Service of the University of Michigan. With additional help, in the form of a grant, from the W. K. Kellogg Foundation six syllibi were prepared as a guide for the formal classroom study through adult education classes. These syllibi are still being used by many of our county chapters, although the course material needs revision to meet the present educational requirements of the members. It is the hope of the MSMAS Education Committee that this revision will be accomplished this year.

IN 1959, ONLY three years after the birth of AAMA, at the insistance of medical assistants all over the country, the AAMA House of Delegates approved the appointment of a special committee to develop a Certification Program. Presently serving on the Certifying Board are three physicians, three educators, six medical assistants (all CMA's), the AAMA president and president-elect, plus an additional medical assistant who serves as the chairman. The goals for this program are as follows:

1. To help physicians identify those qualified as top-level office assistants, administrative and clinical.

2. To establish professional standards and goals for medical assistants.

3. To assist schools and colleges in developing training programs for medical assistants.

4. To prepare and administer an annual examination.

5. To certify those who successfully complete the examination.

Certification is not required for membership in MSMAS or AAMA, but it is an opportunity for the medical assistant to voluntarily upgrade her position. It is not a requirement for holding or obtaining a job as a medical assistant, and, further, it is not an attempt to evaluate her performance on her present job.

The examination is divided into seven sections. All candidates must pass the first three sections of the examination which are:

1. Medical terminology, anatomy and physiology.

2. Personal adjustment and human relations; medical ethics and etiquette.

3. Medical law and economics.

For the Administrative Certificate the candidate must also pass sections 4 and 5 covering:

4. Office skills and procedures; accounting, credits and collections.

5. Written and oral communications; records, medical and non-medical.

The candidates for the Clinical Certificate must pass, in addition to the first three sections, section 6 and 7:

6. Examination room techniques, sterilization procedures and care of equipment.

7. Laboratory orientation.

IN ORDER TO BE eligible for certification testing the applicant must be at least 21 years of age at the time of application, be a high school graduate or sumbit equivalency certificate, have a minimum total of three years employment by a Doctor of Medicine in an office, hospital or clinic, have at least twelve months continuous employment with one Doctor of Medicine, hospital or clinic, and the application must be signed by the current or most recent employer. (Membership in AAMA is not a requirement for certification testing.)

Financial aid was forthcoming from the American Medical Association to help us launch this program. For the past eight years Merck, Sharp and Dohme has contributed an annual grant of $5,000.00 toward the administration of this program.

There has been a steady increase both in the number of assistants taking the examination as well as the number of regional test centers throughout the country. There are now a total of 225 Certified Medical Assistants in the United States, eight of whom are in Michigan. The examination is difficut but it is not impossible for the candidate who prepares for it. It is broader than almost anyone's actual experience; therefore, few persons would be expected to pass without some review and study. A broad study outline of all sections of the examinations, with a list of reference books, is available upon request from the AAMA headquarters in Chicago.

Another step in the educational field for medical assistant is the recent formation of the Approval Program for medical assistants' courses in community junior colleges. Lederle Laboratories gave $5,000 to AAMA for implementation of this program. Until this time AAMA was one of the few para-medical groups that did not have an approval program, and because of this we were not able to recommend training programs to the hundreds of students who requested this information. The ground work has laid for a standardized training course for approved junior colleges throughout the United States — probably a two-year course leading to an associate arts degree in medical assisting. We are hopeful that this will help recruitment of trained medical assistants to fill the ever-increasing need in this field. This is an important long-range program and a major undertaking for AAMA. Northwestern Michigan College, in Traverse City, is one of the colleges participating with AAMA in this program.

Other educational opportunities provided by MSMAS for its members include the annual convention, which is held at the same time and in the same city as the MSMS convention, workshops, seminars and leadership training symposiums.

CONTINUED: MEDICAL ASSISTANTS

Other areas, not to be overlooked, are the *Bulletins* from both MSMAS and AAMA which carry invaluable articles for all medical assistants.

MSMAS IS AWARE of the need to meet the challenge of the "changing times" and will continue to strive to provide the best educational opportunities for all medical assistants and improve the quality (and quantity) of MSMAS inservice training programs.

Together with the high goals and standards we have set for ourselves through our organization we must also have some personal satisfaction by challenging ourselves to be knowledgeable, informed, enthusiastic and have as our first consideration the best interest of our employers and patients. ☐

To Improve Hospital . . .

Many suggestions are made every day to improve the hospitals in Michigan . . .

One of the recent ones at the University of Michigan Hospital was recorded by a 12-year-old boy, who suggested, "I would put the doctors in bed, and let the kids give the shots."

Parke-Davis Scientist Praises Work Performed By Zonal Centrifuge

A Parke, Davis & Company scientist has described the zonal centrifuge as a most useful instrument for large-scale purification of virus vaccines.

Dr. Manuel Rosenbaum, a research microbiologist in the Detroit laboratories of the pharmaceutical firm, said the zonal centrifuge, developed by Dr. N. G. Anderson, under the auspices of the Atomic Energy Commission and the National Institutes of Health, has been used "with great success in the continuous-flow processing of large volumes of crude vaccine materials with very efficient recovery of the immunizing agent and removal of essentially all extraneous matter."

Dr. Rosenbaum said that Parke-Davis had used the zonal centrifuge extensively in research operations, and he felt it would be a very useful adjunct in producing the improved purified-antigen influenza vaccine prepared by the ether-extraction method pioneered in the drug company's laboratories. ☐

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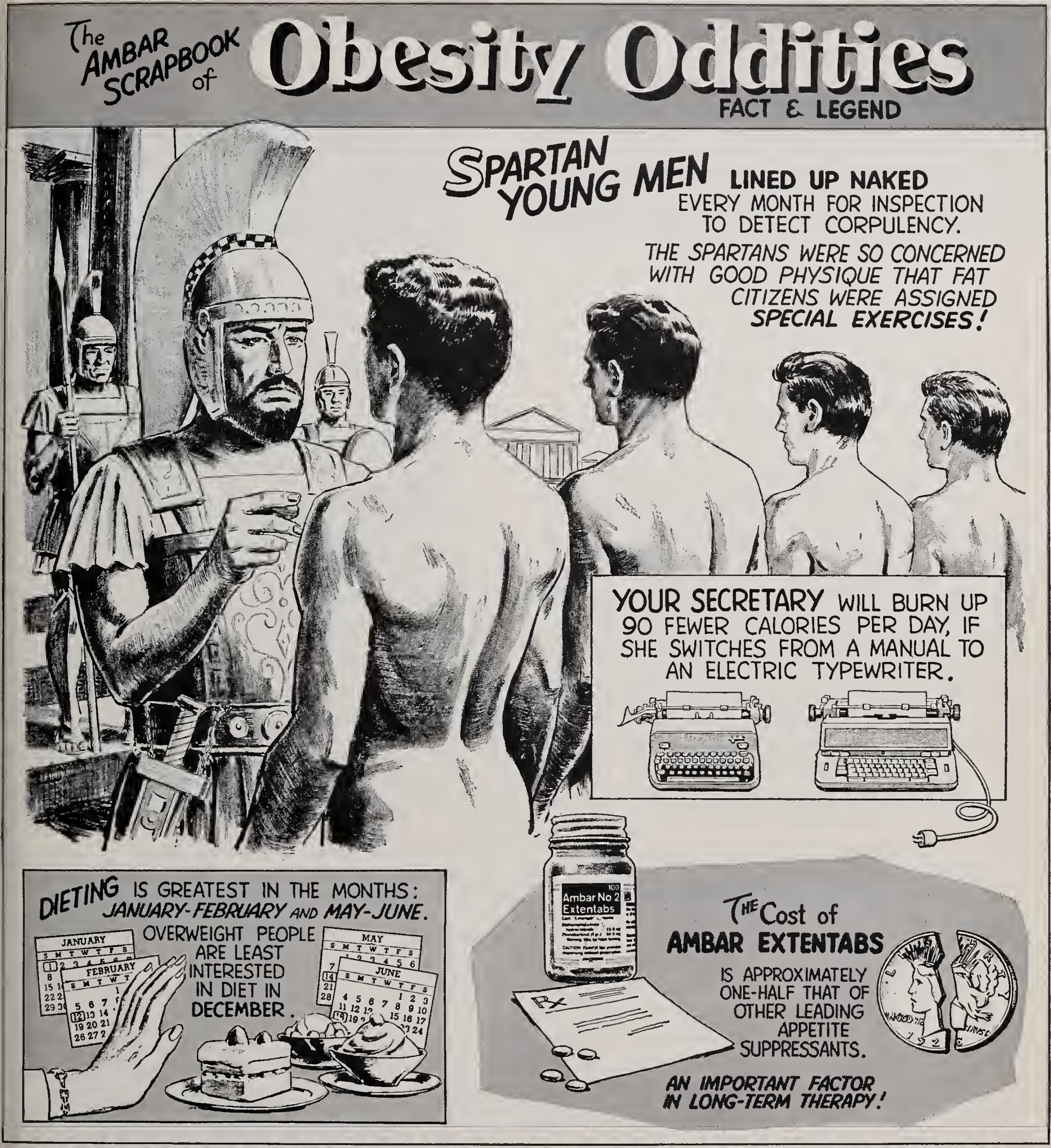
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phenobarbital 64.8 mg. (1 gr.)
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Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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IN MEMORIAM

V. D. Barnes, M.D., Livonia

Van D. Barnes, M.D., retired Livonia physician, died April 7, 1968, at the age of 76.

Doctor Barnes had carried on active practice for 46 years before his retirement. He was a 1915 graduate of the University of Michigan Medical School. Affiliated with U.S. Veteran's Administration hospitals for 30 years, he was a member of staff at the Dearborn V.A. Hospital from 1939 to 1961 and at the V.A. Hospital, Ann Arbor, from 1956-58. During World War I he served as a major in the Medical Corps.

He was a member of the American Legion, Rotary Club and Pi Upsilon Rho medical fraternity.

J. R. McBride, M.D., Lapeer

John R. McBride, M.D., Lapeer physician, died March 28 at the age of 64.

Doctor McBride had maintained a general practice in the Lapeer area for 30 years, having begun practice at North Branch. He received the M.D. degree in 1929 from the University of Iowa College of Medicine. During World War II he served as a captain in the Medical Corps.

LEGISLATURE PAYS TRIBUTE TO NORTHVILLE PHYSICIAN

The Michigan House of Representatives recently adopted a resolution memorializing the work of the late Irene L. Sparling, M.D., of Northville.

Doctor Sparling, who died in December 1967, worked for 40 years in Northville as a general practitioner, specializing in obstetrics-gynecology. She and her husband, Harold I. Sparling, M.D., both opened their practice there in July of 1925.

The conclusion of the resolution reads: "Resolved by the House of Representatives, that . . . a memorial of tribute be accorded Dr. Irene I. Sparling whose early determination to excell in medicine for the sake of future patients carried her to that goal, despite economic handicap; and who kept that trust faithfully, beyond the call of duty, for 40 years without fail." □

After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
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...adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
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Usual Adult Dose: One or two tablespoonfuls three times daily.

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Make tuberculin testing routine
with every physical examination.

TUBERCULIN,TINE TEST
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Should Hospitals Adopt Seven-Day Week?

(Editor's Note: The following is excerpted from an editorial in the Bulletin of the Muskegon County Medical Society. Editor Robert M. Jesson wrote, in part, the following about the possibilities of hospitals operating seven days a week.)

"In view of recent activities in Muskegon, possibly additional service could be rendered to the patient by implementation of a 7 day week in our hospitals. This might interfere with the 3 and 4 day week of some of our colleagues, as well as the tendency of others to hospitalize people for several days ahead so as to obtain a good operating room time, but the lack of a two day gap out of every 7 certainly benefits most patients and doctors. Changes in laboratory service would be necessary too.

"It would seem to be an experiment well worth trying, especially if our local hospital costs are anywhere near that of the national average. Certainly a 6 to 12 month experiment in this could be accomplished with minimum difficulty and would provide some interesting figures for hospital administration.

"This idea should bear consideration in light of the present circumstances.

"It can be started literally overnite."

Established 1924

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* 1904 - 1967

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PUBLIC HEALTH PHYSICIAN: To fill immediate vacancies. Salary range $18,729 to $24,430 annually, depending on qualifications. All Michigan civil service benefits. Two positions available: Chief, Pulmonary Disease Section — supervises all aspects of a statewide program of tuberculosis control; Chief, Section of Preventative Medical Services — Plans, develops, implements, supervises, and evaluates statewide programs in cancer and chronic disease control. Must possess a master's degree in Public Health and be eligible for a license to practice medicine in Michigan. For additional information contact Dr. John Cowan, Chief, Division of Adult Health, Michigan Department of Public Health, Lansing, Michigan. An equal opportunity employer.

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MEDICAL DIRECTOR: for well established Health Department in Allegan County, Allegan, Michigan, serving 60,000 population. Requires: M.D. Salary commensurate with experience. Benefits: Paid vacation, holidays, sick leave and retirement program. Please write: John Pahl, Acting Director, Allegan County Health Department, Allegan, Michigan 49010.

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WANTED: ORTHOPEDIC SURGEON, board certified or eligible to join two-man partnership. Very active widely varied practice. Two fully equipped hospitals. Town of 40,000 on Lake Huron, fifty minutes from downtown Detroit. Excellent living, sailing, recreational area. Starting salary up to $30,000. Association thereafter. Write C. O. Townley, M.D., or S. C. Walker, M.D., 1209 Tenth Street, Port Huron, Michigan 48060 or call collect (313) 982-9923.

HOLT — Ingham County — Badly needs another general practitioner. Free rent for balance of 1968 of newly furnished six room office suite; beautiful air-conditioned building, may also share X-ray room and emergency room. Very reasonable rent after 1968. One of Central Michigan's finest suburban communities, population 8,000 trade area 15,000. One M.D., two dentists in building. GP would have own practice. Size of practice governed by amount physician desires. Prefer graduate United States or Canadian school, militarily exempt. Present M.D. would reciprocate week-end coverage. Adjoins Lansing; three large open staff hospitals. Seven schools in town. All new except one. New housing available. Contact: F. L. Troost, M.D., Holt Medical Bldg., Holt, Michigan. Phone 517-694-6341 Office or 517-694-1341 Home.

WANTED: General practitioners, anesthesiologist, urologist, obstetrican, orthopedist and pediatrician needed in growing community of 15,000. Service area 25,000. Present 83 bed general hospital. New 100+ bed automated hospital to be completed within 2 years. City has excellent industry, school system and recreational facilities. 45 minutes from Madison or Milwaukee. Future unusually promising. For more information, Contact: Administrator Watertown Memorial Hospital, Watertown, Wisc.

PSYCHIATRIC RESIDENCIES: Approved three-year, community oriented, dynamic program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary $9,875; $10,445; $11,234. Five year career program $11,234 to $20,357. Liberal Civil Service benefits. Apartments available. Physicians completed internship four years ago may be eligible for NIMH stipends of $12,000 per year. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

OBSTETRICIAN-GYNECOLOGIST, to take over busy west Detroit suburban Ob-Gyn practice. No investment or obligation. This fine opportunity has developed unexpectedly and available immediately. All qualified applicants given careful consideration. Write Box #10, 120 West Saginaw St., East Lansing, Michigan 48823.

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WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D., or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

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Thomas V. Kretschmer, M.D., Saginaw,

was named recipient of the first distinguished alumnus award presented by St. Mary's High School in Saginaw. He was chosen because "he has been a humanitarian, has set an example of good Christian living and has contributed much to Saginaw," said the pastor of St. Mary's.

A. E. Humphrey, M.D., Marshall,

was honored at a testimonial dinner at Schuler's in Marshall and received a plaque presented by a member of the Social Services Board citing his "dedicated professional and personal service" to the aged and needy of the community.

Richard W. Dow, M.D., Ann Arbor,

an instructor in the U-M Medical School, is one of 25 medical researchers in the nation recently named as Markle Scholars in Academic Medicine. The Markle Foundation pays $30,000 at a rate of $6,000 yearly to the medical school at which a scholar is appointed.

Joseph F. Sadusk, Jr., M.D., Grosse Pointe,

has been elected to the Board of Directors of Parke, Davis and Company. Dr. Sadusk, who has served as associate dean of the Johns Hopkins University School of Medicine and as medical director of the Food and Drug Administration, is presently vice president, medical and scientific affairs at Parke-Davis.

Sidney E. Chapin, M.D., Dearborn,

medical director of the Visiting Nurse Association Home Care Program of Detroit, participated on the program of the 38th Annual Tri-State Hospital Assembly in Chicago. He served on a panel and also presented a paper entitled "Building Physician Support for Home Care."

MSMS MEMBERS IN THE NEWS

BY CAROL MAXWELL
OF THE MSMS STAFF

Michigan
State
Medical
Society

Bonnie R. Wolfram, M.D., Grosse Pointe,

has accepted the chairmanship of a new national committee named by George Lingua, president of the National Kidney Foundation. The committee's purpose is to implement programs for prolonging life and restoring to useful activity victims of kidney failure.

Dr. Wolfram's group, the Trustees' Dialysis and Transplantation Committee, will consider sources for financing of patient care for the 6,000 to 10,000 individuals annually needing artificial kidney treatment (hemodialysis) or transplantation in order to survive.

Jack Lapides, M.D., Ann Arbor,

professor of surgery in the University of Michigan medical school, was presented the William P. Burpeau Award and honored as "one of the nation's outstanding urologists," by the American Academy of Medicine, Urology Section, at a recent meeting of the Academy in West Orange, N. J. He delivered a lecture on "New Concepts Regarding Urinary Infections."

Donald L. Schaefer, M.D., John S. Wyman, M.D., and Robert E. Anderson, M.D., all of Ann Arbor,

were participants on the program of the 46th Annual Meeting of the American College Health Association in Minneapolis.

Paul E. Derleth, M.D., Ferndale, and Norman J. Goode, M.D., Detroit,

were promoted to new positions in the Detroit Edison Company. Doctor Derleth is the new medical director and Doctor Goode will serve as assistant medical director.

Otto Von Renner, M.D., Reese,

longtime Vassar general practitioner, celebrated his 95th birthday recently. "I live very simply, enjoying the common things," he said.

Harold T. Donahue, M.D., Cass City,

was named Cass City Citizen of the Year at a recent Chamber of Commerce dinner.

Muir Clapper, M.D., Detroit,

Professor of Medicine at Wayne State University School of Medicine, has been elected to a three-year term on the Board of Governors of the American College of Physicians. Elections were held at the College's 49th Annual Session in Boston recently.

MICHIGAN MEDICINE

Many Articles

In every issue of MICHIGAN MEDICINE there are articles of value and interest to every MSMS member. Some members want scientific papers, others primarily want information about MSMS and its projects, others want to read about the activities of the many ancillary organizations, and still others have other special interests. This July issue and every issue offers a blend of all these articles. Comments are always invited from MSMS members as are original scientific articles.

RECOMMENDED

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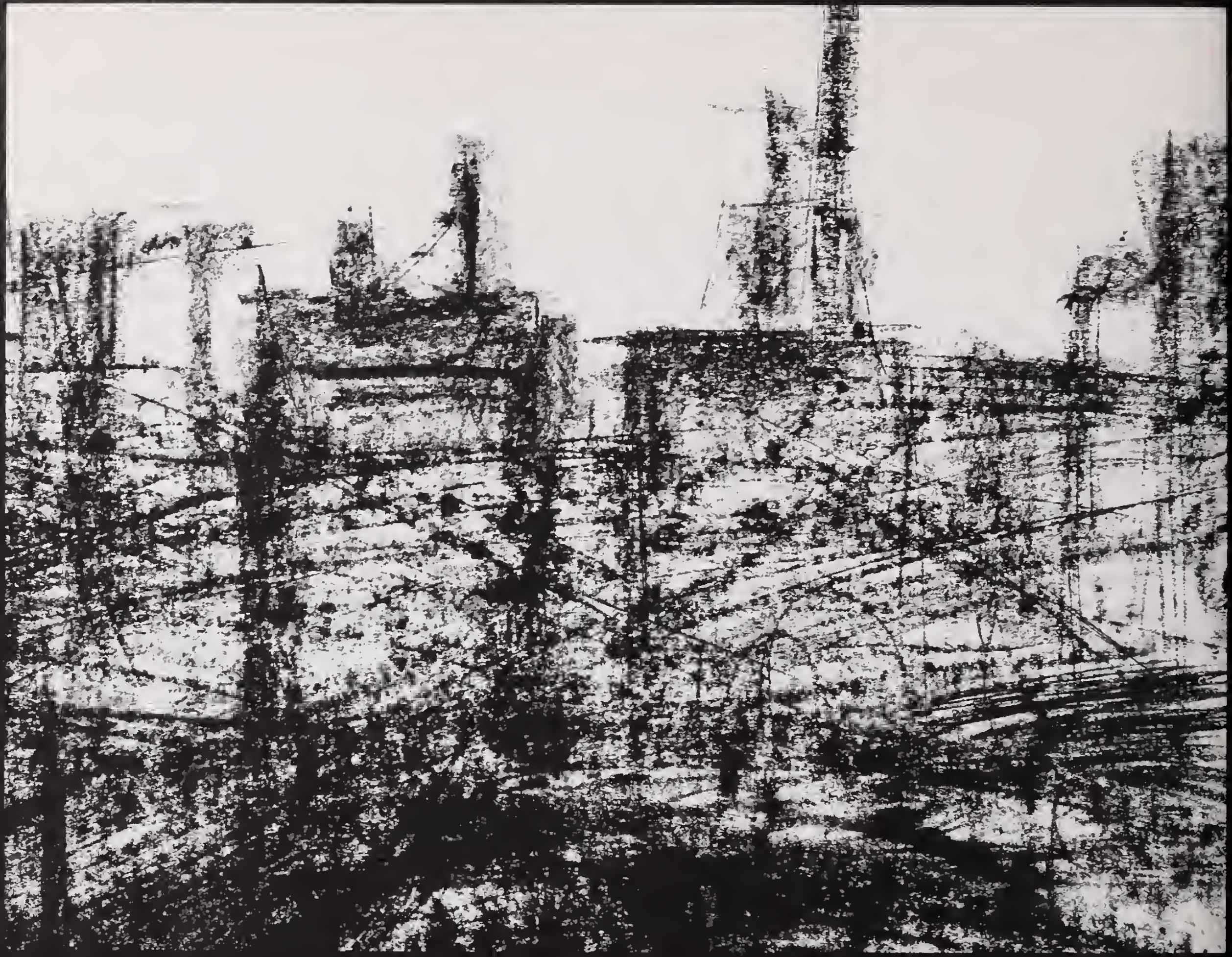
MICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 13 JULY 1968

MARK YOUR CALENDAR — ALL IN DETROIT

Sept. 22-24 — MSMS House of Delegates
Sept. 25-26 — MSMS Annual Scientific Session
Sept. 24-26 — Woman's Auxiliary to MSMS
Sept. 25-26 — Michigan State Medical Assistants Society
Sept. 22 - Oct. 20 — "Ars Medica Art Exhibit"



SEPTEMBER 25-26, DETROIT
1968 MSMS ANNUAL SESSION

SEPT. 25-26
is the time to participate in the 103rd MSMS Annual Session. Listen to medical authorities, participate in conferences, see the exhibits, enroll in a one-day course, visit with your confreers, attend a specialty session, have fun at the Annual MSMS Dinner Dance, etc., etc.

SEPT. 25-26
the time to enroll in one or two of the special day-long courses in "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases," "Difficult Decision in Digestive Diseases." Courses will be limited.

SEPT. 25-26
is the time to see the latest advances in medical research, products, and equipment in the Exhibition Hall at the Sheraton-Cadillac. The exhibitors help make the Annual Session possible; and make valuable contributions to the MSMS postgraduate medical efforts.

SEPT. 25-26
is the time to take a break from your busy office and hospital routines. Block out the dates now on your appointment calendar. Watch future issues of Michigan Medicine for more details.

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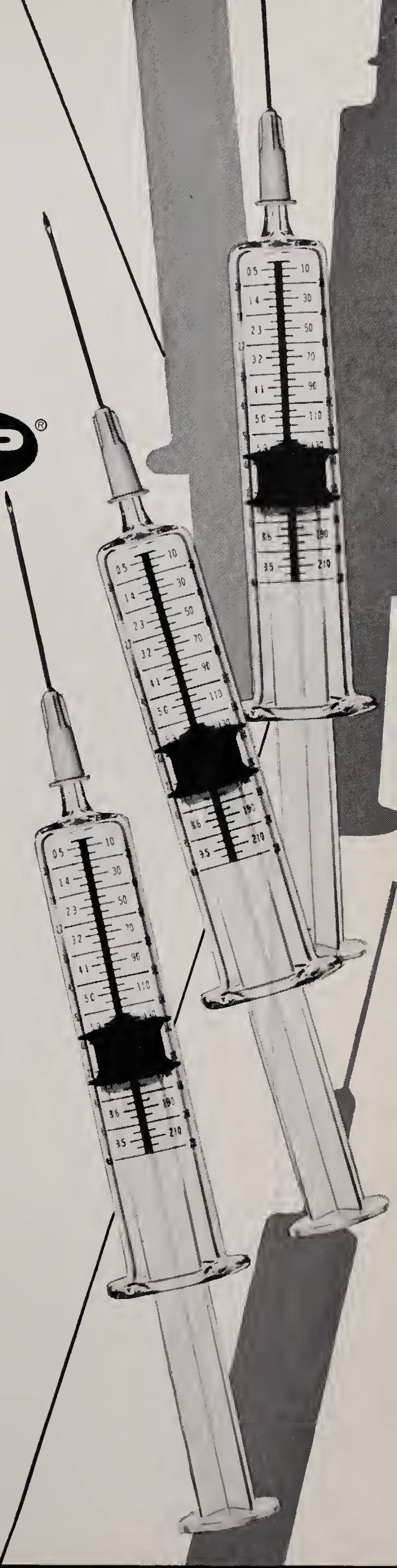

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CREDITS:

The art work on the MSMS Annual Session ad on the inside front cover is a charcoal sketch "Cityscape" by Mrs. Clara Rogers of Birmingham. It will be used throughout the summer in all the MSMS promotional efforts for the Annual Session to be held in Detroit, September 25-26. Mrs. Rogers works in many media and has had many works on exhibit in Detroit and other cities.

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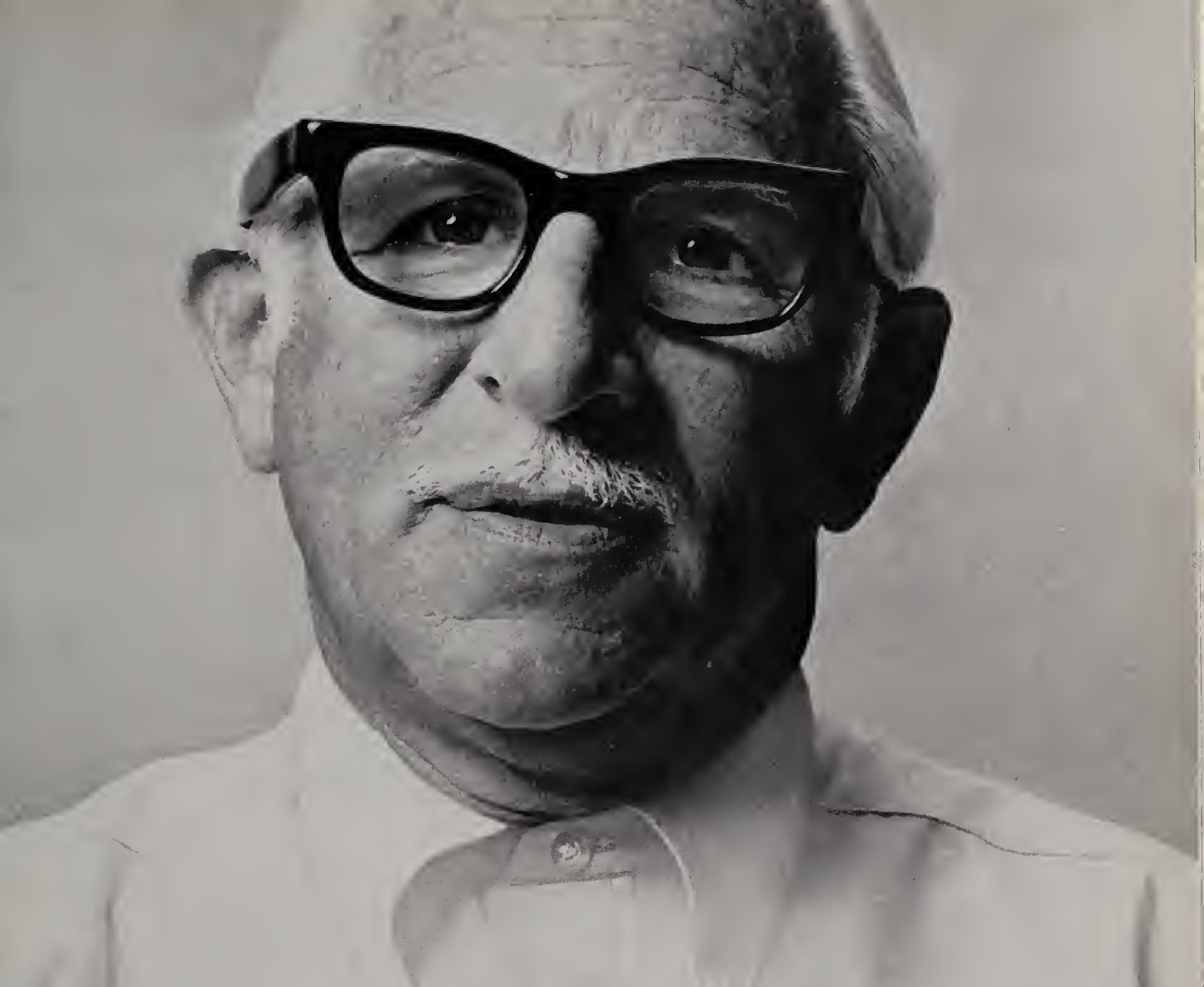

He is elderly,
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he may be a candidate for

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Demethylchlortetracycline HCl 300 mg
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ıtin is combined with demethylchlortetracycline in
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r your susceptible candidates, prescribe DECLOSTATIN
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and liver toxicity. Under such conditions, lower than usual doses
dicated, and, if therapy is prolonged, serum level determinations
e advisable. A photodynamic reaction to natural or artificial sun-
ıas been observed. Small amounts of drug and short exposure may
ce an exaggerated sunburn reaction which may range from ery-
to severe skin manifestations. In a smaller proportion, photo-
c reactions have been reported. Patients should avoid direct
ıre to sunlight and discontinue drug at the first evidence of skin
nfort. Necessary subsequent courses of treatment with tetracy-
should be carefully observed.

ıtions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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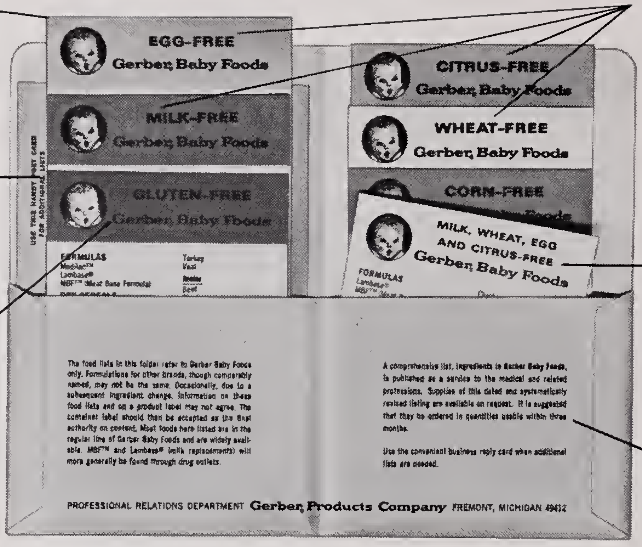
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Separate lists of foods free from four common allergens.

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A list of foods free from milk, wheat, egg and citrus fruit.

An individual list of gluten-free foods.

Lists are revised frequently by Gerber nutritionists.

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Infant "Survival Kit"

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With these new Gerber food lists you can institute a variety of test diets based on strained or junior Gerber Baby Foods. All lists permit selection of a varied and nutritionally adequate diet. Even when you use Gerber foods free from the combination of milk, wheat, egg and citrus fruit, your infant patient is allowed two milk-free formulas, three different cereals, two juices and *thirty-five* Gerber strained foods. Toddlers, in addition, may receive nine fruits, five vegetables, six dinners (three are high-meat), plus a cereal-fruit combination and a dessert. A total of *twenty*-seven junior foods.

Two formulas for the milk-sensitive patient.
When using this exclusive Gerber nutrition plan, you have your choice of two superior formulas for adequate nutritional replacement of milk proteins and other nutrients: (1) Lambase,® the premodified formula containing 24.4 Gm. of lamb-based protein per quart, (2) MBF™ (Meat Base Formula, beef) the higher protein formula (27.5 Gm. per quart) that allows your choice of added carbohydrate modifier. Both are unexcelled in protein quality.

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For the infant who is not sensitive to milk, Modilac, Gerber Baby Formula, supplies 21.6 Gm. of protein per quart when fed at the recommended dilution of 1:1. And, Modilac being of intermediate protein content, is not overly dilute in other essential nutrients derived from milk.

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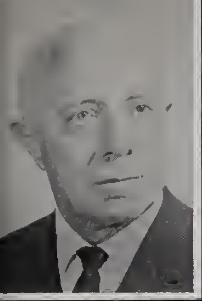

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Through a United Voice

Have you heard the following question recently?

"Why should I belong to or be active in the AMA or MSMS?"

Perhaps you have.

I have.

And I've enjoyed discussing the question with some of the medical students, with some of the physicians under 39 and with some of those over 39. And I've had strong support from time to time from the students and from those both under or over the Jack Benny-age of 39.

My answer to the question and the supporting comments of many Michigan physicians seem to shape up this way:

> *Physicians are living in a social, economic and governmental climate which requires medicine to present the strongest, positive voice possible to state the profession's side to the hundreds of issues that are being discussed by the public, the educators, the students, the planners, the media, and the lawmakers.*

I hope you will agree with my answer, which in effect says, "in unity there is strength." Every physician through his county medical society, through MSMS, and through the AMA should raise questions and present his own point of view. He should have the opportunity to serve on committees, to strive to become an officer, to function as a delegate.

In our medical organization we must take advantage of the opportunity to debate the issues and to re-examine our philosophies. This is possible; and I hope can result in a minimum of public disagreements which dissipate the strength of our united voice, stand and action. A complete consensus is not possible; and probably not even desirable. But the issues must be studied, debated and tackled by physicians as professional men and women—well-educated and well-grounded in ethics.

We all have often repeated the famous quotation, "I disapprove of what you say, but will defend to the death you right to say it." This is my feeling too.

> *Physicians who treasure their opportunities to serve mankind and who love the profession will want to offer constructive suggestions and will work through the existing, democratic channels to bring about progressive changes.*

The AMA President, Milford O. Rouse, M.D., put many of my reactions together well in a speech recently when he said: "As physicians, we can best play our role in the continuing and increasing debate that is going on in this country regarding welfare, governmental power, and all other elements of our political, social and economic lives by working in unity, in harmony, and by focusing all our efforts into one main channel of communication through a united voice." ☐

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turbances of accommodation, sw
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frequency or retention, nausea an
vomiting, peripheral neuritis, mild
parkinson-like syndrome, tremors
rare cases of falling in elderly pa-
tients, confusional states (with su
symptoms as hallucinations and c
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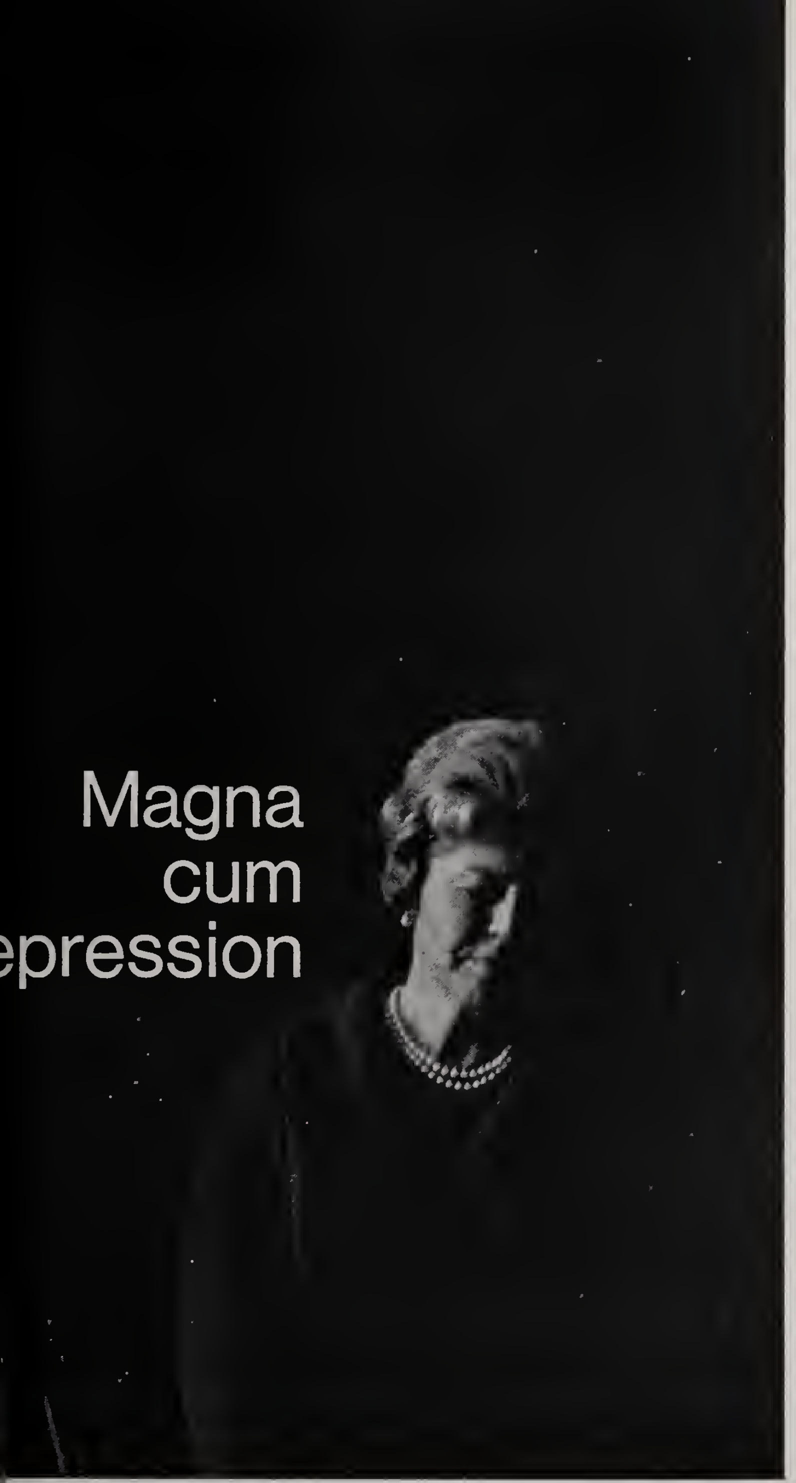

For him, commencement.

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Has Emergency Care Plan Been Tested?

BY BROCK E. BRUSH, MD, CHAIRMAN
MSMS PUBLIC RELATIONS COMMITTEE

"The MSMS component medical societies should take the leadership in developing an emergency medical care plan and in conducting an annual trial run."

That is a recent motion of the MSMS Committee on Public Relations that was approved by the MSMS Council, and thus routed to the 55 component societies across the state.

Many of the county medical societies have helped to develop workable patterns to provide medical care in case of any disaster. The need for an emergency plan can face any community in Michigan when we consider the growing possibilities of multiple car accidents; train, bus or airplane accidents, tornado or other weather problems; industrial mishaps; fires, etc.

The second part of the emergency care concern voiced above rates special attention. It is fine to have a plan on paper — but it is essential that the medical profession be sure that there is "an annual trial run." Some of the counties fortunately have found weaknesses in the on-the-paper-only plans, and have been able to correct them after a test.

The county medical society — because the physicians are the only ones that can provide the medical treatment that would be needed during and after an emergency — should anticipate such a situation and should gather together the appropriate agencies and persons to perfect an emergency medical care organization. The physicians will want to get the advice and involvement of the city governmental officials, communication executives, ambulance services, the scouts and other volunteer helpers, etc.

In developing a pattern, these people will want to explore all the needs for blood banks, blood substitutes, bandages and dressings, drugs, stretchers, respirators, etc. The plans for facilities should include not only the hospitals but also the school gymnasiums, military armories, etc.

To be sure that the injured will receive the right treatment and care, it would be well to select a triage officer who would decide upon the urgency of the cases and would establish priorities.

The county medical societies which have good plans already tested in 1968 can consider many related projects. One of the good complimentary activities would be for the medical society to sponsor a seminar on trauma — or a workshop on shock — and thus provide information and experience for the many ancillary people who are always needed when emergencies do arise.

Physicians are eager to provide prompt and efficient handling of every emergency victim — and the component societies must assume the responsibility of organizing the total team and testing it for functional flaws. ☐

Who Carries on Now On Manpower Report?

BY ROBERT J. MASON, M.D., CHAIRMAN
THE MSMS COUNCIL

Surely you have read many articles recently about the Report of the National Advisory Commission on Health Manpower. I certainly have.

Newspapers have picked up some of the more spectacular aspects, some social planners dismiss it as too mild, and the medical profession has approved and agreed with many of the proposals in the Report.

Today, we ask "who carries on from here?"

THE PANEL OF EXPERTS who conducted the study and wrote the Report has completed its work.

The physicians or medical profession really can't implement all the recommendations alone.

Then who should?

PERHAPS ONE PORTION of the Report itself provides a possible answer. In part the Report declares:

> *"There is a crisis in American health care. Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel. This report, therefore, deals primarily with what can and should be done now. . . .*
>
> *"At first blush, this might sound as if we are about to propose the creation of a master Federal plan for national health care. Not so. We are convinced government alone is not big enough to solve the problems of health care for the American people. Our recommendations require that the resources of each*

of these powerful forces (the professions, voluntary agencies, religious and educational institutions, hospitals, organized labor, business and industry, and concerned citizens) be applied to reshape effectively the health care system."

Maybe the suggestions are in the last sentence? If the problems of health manpower and health care must be solved, then the medical profession must be involved and must take the leadership. We cannot, however, dismiss the possible contributions by many other forces. Medicine, it seems to me, cannot ignore the potential good that a coalition of physicians, nurses, technicians, social workers, voluntary agency officials, governmental executives, and other interested parties.

AMA President-Elect Dwight Wilbur, who served as a member of the Commission, has suggested that the Report will serve as a major basis for future legislation dealing with health care.

THE OPPORTUNITIES ARE here for medicine and the individual physician to become informed about the recommendations of the Report, and to get involved in seeking solutions to the many problems facing the physician and the patient alike.

Who can really understand the problems better than physicians and actively seek workable solutions? The Report provides a framework that can be altered and modified.

Who carries on from here?

AMA Legislative Challenge "Never So Formidable"

BY DONALD E. WOOD, M.D., CHAIRMAN
AMA COUNCIL ON LEGISLATIVE ACTIVITIES
INDIANAPOLIS, INDIANA

Never before has the task for the AMA Council on Legislative Activities been so formidable as it is today.

And never before has this scope of AMA activities been so strong a reason for every physician to belong to the AMA.

Under the "Great Society," a once-steady stream of 300-or-so bills has swelled into a torrent of proposed legislation that has severely challenged the energies of the Council members and their nine-member AMA staff, which includes three attorneys, one a legislative attorney permanently assigned to the Washington Office.

KEEPING TRACK OF whatever pops into the Capitol Hill legislative hopper that can have any direct or indirect bearing on the medical profession or public health long has been an obligation

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carried out by the American Medical Association on behalf of the medical profession.

Through the years this task has been performed by the AMA's Council on Legislative Activities, 13 perspicacious physicians appointed by the Board of Trustees, and its predecessors — the Bureau of Legal Medicine and Legislation and, prior to 1924, the Council on Health and Public Instruction.

ALMOST OVERNIGHT HEALTH care has been catapulted into a position of paramount national concern. The successes of American medicine have led to an increasing demand, and there has been a pervasive search for ways to obtain more health care services through legislation.

The legislative statistics clearly speak for themselves. During the 88th Congress (1963-1964), for example, the AMA Council and its staff analyzed 860 bills of medical interest. Before the 89th Congress adjourned in 1966, that record activity on health legislation was paltry in comparison. In that session attention was focused on 1,526 bills. And in the first session of the 90th Congress (1967) another 1,127 bills had gone into the hopper.

This surge of legislative activity is reason enough to again focus attention upon the roles carried out by the Council in the interests of organized medicine. Since laws are drafted by legislators and others who seldom are experts in the areas their bills seek to cover, it is imperative that the proposals be weighed and judged by those whom they would directly affect — in this case, physicians and their patients.

AS REPRESENTATIVES OF the medical profession, members of the AMA Council and their staff have the responsibility of scrutinizing each bill of medical interest, striving to determine its strengths, its weaknesses, its immediate and long-range effects, its ramifications and subtle implications, if any.

After obtaining the expert views of many interested parties, the Council makes recommendations to the Board and these, sometimes, compel the need for policy-making decisions on matters of significant import.

Matters of the greatest interest to the profession occur in broad areas affecting medical education, medical practice, construction of health or teaching facilities and provision of medical services.

To effectively present the case for or against proposed legislation expert physician and non-physician witnesses are summoned to present AMA testimony before Congressional committees and sub-committees. During the first session of the 90th Congress, the Council developed 16 statements concerned with 11 legislative proposals. Of these

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11 legislative issues, the Association favored six, opposed two and voiced partial support or opposition — or suggested an alternative approach — to the remaining three.

Even after laws are passed, the AMA Council continues to seek modifications which it deems to be in the best interest of the public and the profession. □

Patience, Understanding, Loyalty, and Work

BY W. G. GAMBLE, JR., M.D.,
EDITOR, BAY-ARENAC-IOSCO

One cannot afford not to participate in so-called political medicine. If one expects to avoid some of the changes that bureaucracy is imposing upon us from the state and national levels. It is our duty, each and every one of us, also the members of the Auxiliary, to extend a helping hand in advising others on health care. Fight for what you think is right but also accept the inevitable in some cases.

We cannot always afford to be "agin" everything. We must have an alternate constructive plan of our own. Hospitals all over the land are encroaching a certain amount on the practice of medicine and some of these we cannot help. To others, we should be sympathetic and to other problems we should offer constructive solutions.

It is well for us to remember that those whom you have placed in office and have appointed you on certain committees should assume these duties and feel honored. Prepare to serve in these capacities. Practicing a policy of going into a corner and sulking is of little value. In other words, if you don't play it my way, I won't play. Physicians are supposed to be intellectuals.

Unless we furnish constructive, sympathetic leadership in health care, other powers that be may step in and tomorrow may be too late. Destructive criticism of your fellow physician is lethal poison to all physicians. As there is enough sickness in our land to provide us with a comfortable living, we should extend a helping hand to each other and then help the community as a whole.

The title of this was "Patience, Understanding, Loyalty, and Work." One cannot predict a rosy future and medicine will not go on the next few years as it has gone on in the past. Give of yourself "so that the bread you have cast upon the waters may return to you ten-fold."

(Note: the above is quoted from the Bay-Arenac-Iosco Bulletin. Doctor Gamble is the editor.) □

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Scientific Contributions, Suggestions Welcomed

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

With the multiplicity of journals and subspecialty journals extant, one might consider the role and/or necessity of state society journals.

To many individuals the state society journals still have significant functions. These functions embrace two aspects, (1) Informational and (2) Scientific.

AT THE PRESENT time the medical profession and allied fields are in the midst of a revolution. We are buffeted by socio-politico-economic and other changes. The state society journal is the best means available of keeping our members aware of the changes and proposed changes in these spheres. With awareness of the total picture our members should be in a better position to make proper decisions and play an active role.

Similarly, we all tend to lead a rather insular existence. The state journal is a means of educating our members as to what is going on in other parts of our state, what various groups are thinking and doing, and what facilities are available in other parts of our state.

We are all aware that MSMS has committees and elected representatives who work hard in our behest, although we are not equally aware of what they are doing. The state journal is a means of disseminating information pertaining to the activities of these groups.

FROM THE SCIENTIFIC aspect the state journals have a great deal to offer. It is true, one does not expect to find the discovery of the year in a State Society Journal. Inasmuch as most members of our society have their usual scientific journals depending on their individual needs, the state society journal should give a little bit to everybody. The reader should get an insight into ob-gyn, ophthalmology, psychiatry, public health, etc. All groups should expect to get a generalized view of the total medical picture and have a better understanding of all modalities.

The scientific section should give our members an opportunity to whet their writing tools and build a bibliography.

The state journal should be a means of making people, locally and nationally, aware of the medical advantages of the area. This can boost the state medically and entice younger men to settle and practice in the state. The state journal is a place to express our pride in the medical fraternity and facilities we have.

WE INTEND TO appoint a group of associate editors hoping thereby to involve more of the universities, regional areas and subspecialty groups to make *Michigan Medicine* truly a state-wide journal.

As Scientific Editor, I welcome your scientific contributions and would be happy to have your suggestions to make *Michigan Medicine* the foremost state medical journal. ☐

MD on Hospital Boards Really a Local Issue

BY BROOKER L. MASTERS, M.D.,
CHAIRMAN, PUBLICATION COMMITTEE

Several months ago, MSMS President B. M. Harris, M.D., wrote a President's Message about the need for physicians on hospital boards of directors.

We know that the MSMS and the AMA has taken such a stand. We know too, that the recent Report of the President's National Advisory Commission on Health Manpower made the same assertion.

But this problem, to a large degree, must be tackled by physicians at the local level.

WHEN ARE WE GOING to begin to let people know that the local hospital governing board with no physician member is not soundly constituted?

The residents of the local community and the leaders who select the hospital board members would not do business with a bank that had no bankers on its board of directors.

WHY DO MOST LOCAL hospitals in Michigan — and the nation — continue to be directed by governing boards which includes no one who is qualified to operate a medical institution or to practice medicine?

Within the walls of the hospital where we practice we should be able to make our voice heard . . . within the same walls the best possible medicine must be practiced in the best possible conditions.

AGAIN I ASK, HOW can a governing board formulate hospital policies and make management decisions to provide the best possible conditions for medical care — when participation by the very individuals knowledgeable in the practice of medicine is merely advisory?

Physicians must continue to seek a voting seat on the local hospital board of managers. And physicians must find other local people willing to listen to the cold logic of the positions taken by MSMS, the AMA and the recent National Advisory Commission. ☐

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MAILBAG

(Note: The AMA News *recently reprinted a* Michigan Medicine *editorial by George H. Lowrey, M.D., about foreign doctors. The following letter was received from a foreign physician now in New York City.)*

Dear Dr. Lowrey

I would like to express my sincere appreciation for your comments regarding foregin doctor in AMA *News;* I must say this is the first time for me to know there are some reasonable people in the field of medicine.

AS you know in the other professional field ex. in the arts if you speak with accent they will consider this as an expression of elite. Please don't misunderstand that I am try to put foregin doctor as an elite. I agree 100% with you that there should not have prejudice against us. It is easy to say but it takes a great man like you to express in public.

Sincerely yours
A foreign M.D.

Recently, I had the unpleasant experience of attempting to train a new "Girl Friday" in all office procedures, and found that I learned a great deal about why secretarial paper work is so time-consuming. The time involved in completing the most frequently used insurance forms appears to be inexcusable, and probably remediable to some extent.

Blue Shield, Medicaid, and Medicare forms all involve a great deal of copying of numbers, in addition to the patient's (or subscriber's) name and address. Not only is this subject to error in transcription, but the information must be recorded on several lines, and in no relation to the order in which the name, numbers, etc. is set forth on the identification card issued to the patient. And this is all in addition to considerable medical information which may or may not have any bearing on the claim, and which may be repetitious.

I would strongly urge that the State Medical Society insist that something be done to make matters easier, for both physician and his secretary. I would propose that each patient be issued a plastic identification card, that contains all the necessary information for processing a claim, and that can be run through a franking machine like an oil company or any other credit card, onto the insurance claim form (be it Blue Shield, State, or Federal Assistance Program). This would obviously eliminate error in transcription of names and numbers, and could save 5-10 minutes per form. The identification cards should be designed so that a single franking machine would handle all kinds.

The alternative to improvement in the present system would be unpleasant: either a charge to the patient for filling out unnecessarily cumbersome forms or refusal to process them.

Mark C. Levine, M.D.
Flint

I recently read the editorial in the March, 1968 issue of the Michigan State Medical Society Journal and was pleased to see the stand the State Society is taking on the proposed four-year medical school at Michigan State University.

On behalf of all of my colleagues here I thank all of you for your support of the MSU College of Human Medicine. We look forward in the years ahead to considerable cooperation in further broadening and improving the delivery of health care to the citizens of the State of Michigan.

It has now been well over a year since the State Board of Education recommended to the Governor and to the Legislature the approval of the clinical years, but the legislative action has not yet occurred. We hope that it will come about before too long in order that we might produce more practicing M.D.'s for the citizens of our state.

Again, thank you very much.

Howard R. Neville, Provost
Michigan State University

I was impressed with the very nice February issue of the Michigan State Medical Society Journal which did a very nice job in presenting some of the problems in Viet Nam. I am sure your work has acted as a good stimulus for further thought about the medical aid situation and probably will interest physicians in volunteering. Keep up the good work.

Alfred B. Swanson, M.D.
Grand Rapids

Congratulations on the great improvements you are bringing forth in the *Michigan State Medical Journal.* The book certainly would have to rank among the top five of all the state books, if not higher.

—Russell F. Staudacher,
Executive Director
Student American Medical Association

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Don K. Alexander, M.D., 301 N. Ingalls Street, Ann Arbor, 48104

Wm. L. Beauregard, M.D., 3535 W. 13 Mile Road #606, Royal Oak, 48072

James A. Bennett, M.D., 8900 Mason, Taylor, 48180

Theodore I. Bergman, M.D., 7330 W. Seven Mile Road, Detroit, 48221

Iam P. Bhisitkul, M.D., 1 South Fifth St., Niles, 49120

Charles W. Davenport, M.D., 2311 E. Stadium Blvd., Ann Arbor, 48104

Ralph R. Edminster, M.D., Sparrow Hosp. Path. Dept., Lansing, 48902

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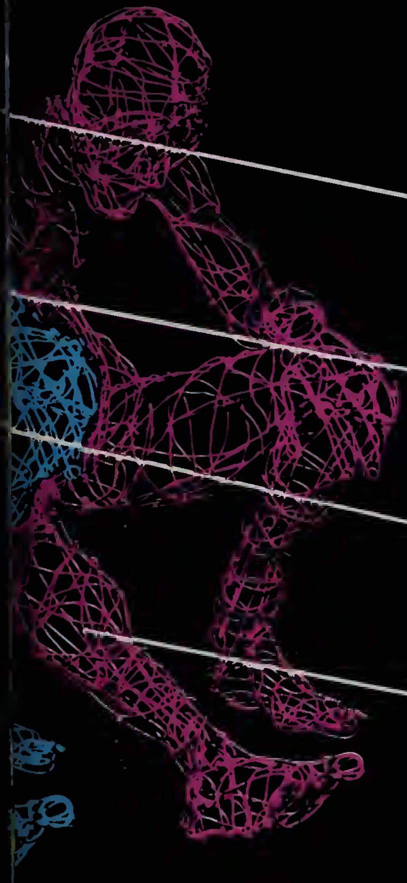

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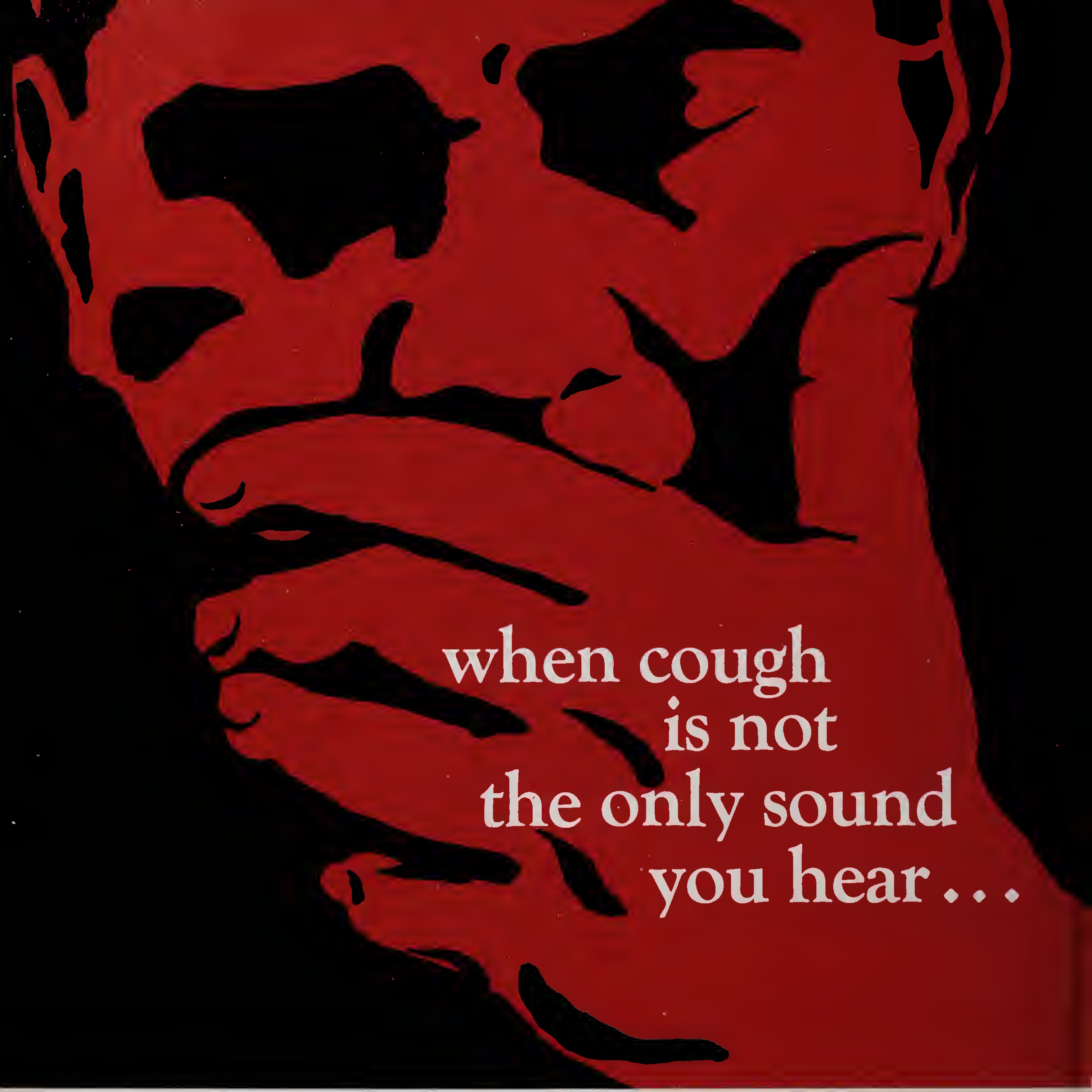

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So Drop Dead at 25

FROM LOUISVILLE COURIER-JOURNAL

(Note: The following editorial was originally carried by the Louisville Courier-Journal and understandably has been reprinted many times. We thought our MSMS members would enjoy it. —B. M. Masters, M.D.)

While the FCC is berating television for its cigarette commercials, we wish it would look into another aspect of TV ads aimed not at corrupting the youth but at demoralizing the adult. In TV commercials, nothing good happens to anyone past the age of discretion. Life not only doesn't begin at 40, it ends at 25.

Watch the people in these ads for a while. Teenagers invariably have great, glistening teeth. Adults have dentures and denture breath. Boys switch hair grease and girls are glad. Men don't have hair. If they do, it is full of dandruff.

BOYS DOUSE THEMSELVES with shaving lotion and wait to beat off the women, like traps full of cheese. Older men are happy to find something that drains all eight sinuses.

Young people have fun. Older people have nagging headaches. Young people spend all night wolfing hamburgers at amusement parks or beach parties. Older people go to a nearby movie and have to leave because their stomach is killing them. Girls have yards of blonde hair full of body and boys nuzzle it. Wives have gray hair and their husbands won't take them dancing.

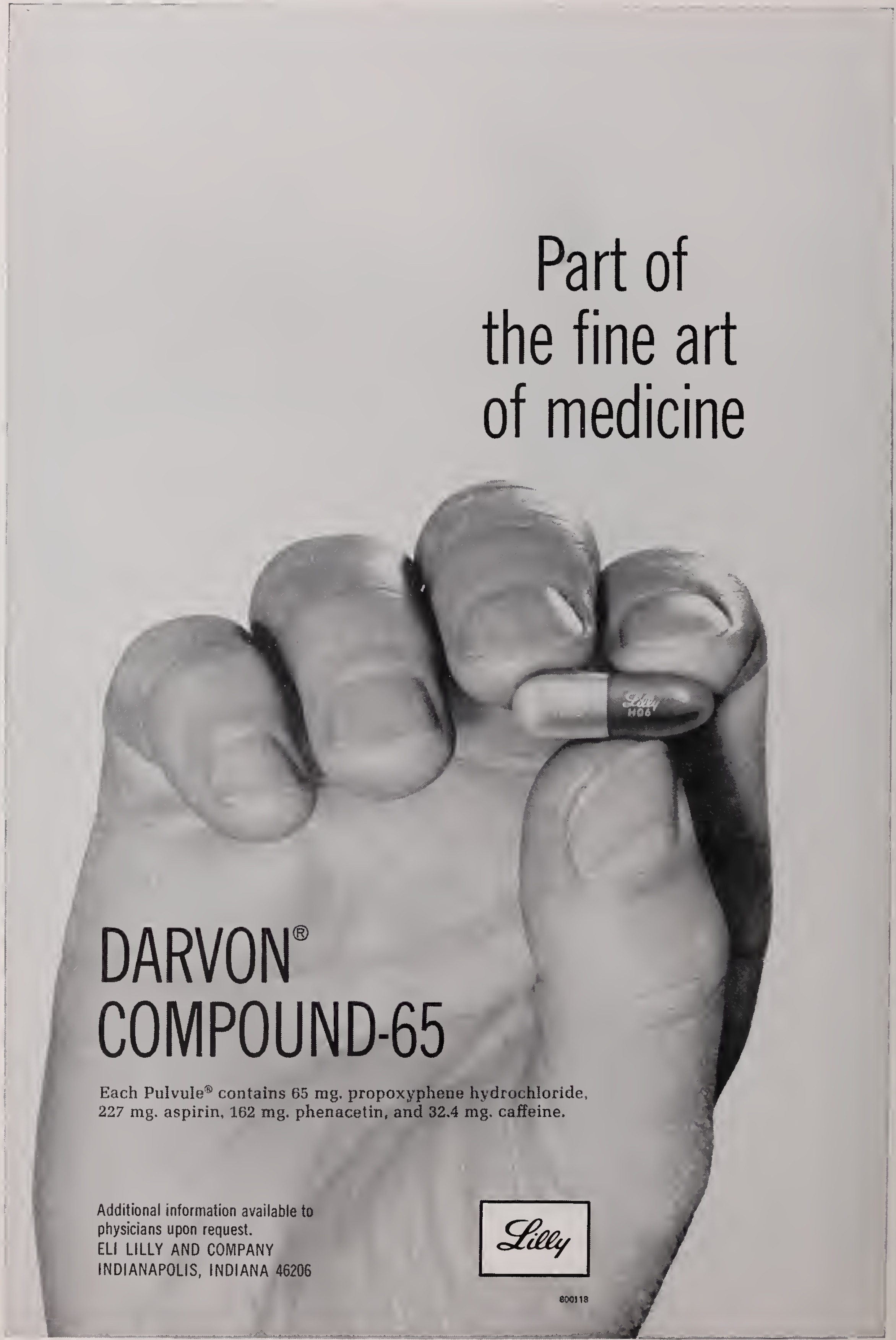
MEN WORK HARD and get ahead, only to have some pimply assistant tell them they have bad breath. The teenage wife makes a cup of coffee and turns her husband into a sex maniac. The older wife washes, irons, mops floors and puts up with birds on the sink, and her husband comes home with a miserable headache and takes it out on her. Girls are always washing their hair. Wives are always washing dishes.

Teen-agers wear sneakers and sandals. Adults wear support hose. Teen-agers rub each other with suntan oil. Adults rub each other with liniment.

ADULTS GET HAY fever and sneeze. Young people are always at the end of a glorious evening. Adults are always at the end of their rope.

Life is fun, fun, fun for the young. They can laugh even with their mouths full of hair. About the only happy time for an adult is when he has an accident and the insurance company pays off. It isn't fair!

Worse, we have a feeling that it's all too true.



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Acute Arterial Occlusion

ABSTRACT — A brief outline of the causes of acute arterial occlusion with particular emphasis given to arterial embolism. A series of cases is analyzed as to immediate results and most importantly, the prognostic significance for life expectancy after an arterial embolic episode.

BY J. A. BARSS, M.D., F.A.C.S.
PORT HURON

Acute arterial occlusion may be considered one of the true surgical emergencies. In most of these cases, the results of treatment depend on the early alleviation of the circulatory obstruction. In general an acute occlusion of an artery is caused by one of three factors: sudden *thrombosis* at an area of atherosclerosis or in a graft, *trauma,* or *embolization.* Other unusual factors, such as intra-arterial catheterization or graft kinking may occasionally produce an occlusion.

Thrombosis is always the terminal event in atherosclerotic occlusion. Usually more than 70% of the arterial lumen has been occluded before thrombosis occurs. In most of these cases symptoms of vascular insufficiency have been present in the affected extremity before the terminal event, or there has been previous arterial grafting in the area. The specific treatment of this type of occlusion requires more discussion than can be included in this presentation and has been covered widely in the literature. Accurate diagnosis is required and replacement by grafting or bypassing the occluded area are the most common methods of handling the situation. Occasionally, endarterectomy may be suitable.

INJURIES TO THE ARTERIES of the extremities have been studied extensively by DeBakey in his analysis of 2,471 cases in WWII[1], and others. The principles of treatment of these injuries are to replace blood loss, remove damaged tissue, and to re-establish arterial circulation by means of direct anastomosis or autogenous vein graft. The use of plastic prostheses is considered hazardous in the presence of possible contamination. Simple ligation of the popliteal artery resulted in 72.5% amputations in DeBakey's series, demonstrating the value of reconstructive surgery. A shotgun wound of the popliteal artery is shown in (Figure Ia), and repair by vein graft (Figure Ib).

To illustrate one of the unusual causes of arterial occlusion, we have had a case in which a dacron aortic bifurcation graft, put in under tension, one year later completely kinked both iliac limbs, requiring excision of the kinked segments and reanastomosis (Figure II). Recently, Fogarty has reported 10 cases of arterial catheterization which caused occlusion by arterial dissection and thrombosis.[2]

The main portion of this presentation will deal with arterial embolization, excluding visceral and intracranial emboli. The first successful embolectomy was performed in 1911 by Labey. Papaverine was introduced in 1934. In that same year, the use of sympathetic block was described by LeRiche and Fontaine.[3] After the later introduction of anticoagulants, the non-operative approach to arterial emboli, especially those affecting the upper extremity, was popularized. Poor results with conservative treatment, however, and the introduction of the balloon catheter by Fogarty have made surgical treatment the most effective approach to this problem. The use of low molecular weight dextran has been reported to be helpful, but is not a substitute for surgical removal of the embolus.

Our series consists of 27 emboli treated in 22 patients. (Table I.) There were 18 males and 9 females with an average age of 70. The source of the embolus in 20 cases was the heart, and in the remaining 7 the embolus came from the aorta. The emboli were located at areas of bifurcation of the arteries, most commonly the femoral.

Many of the patients had significant disease processes at the time of embolization. Severe heart disease was present in 14 patients, and 8 of these were fibrillating. Four were diabetic and 7 other serious conditions were present in the patients in this series. (Table II.)

AUTHOR

The author, Doctor Barss is in practice as a surgeon at Port Huron.

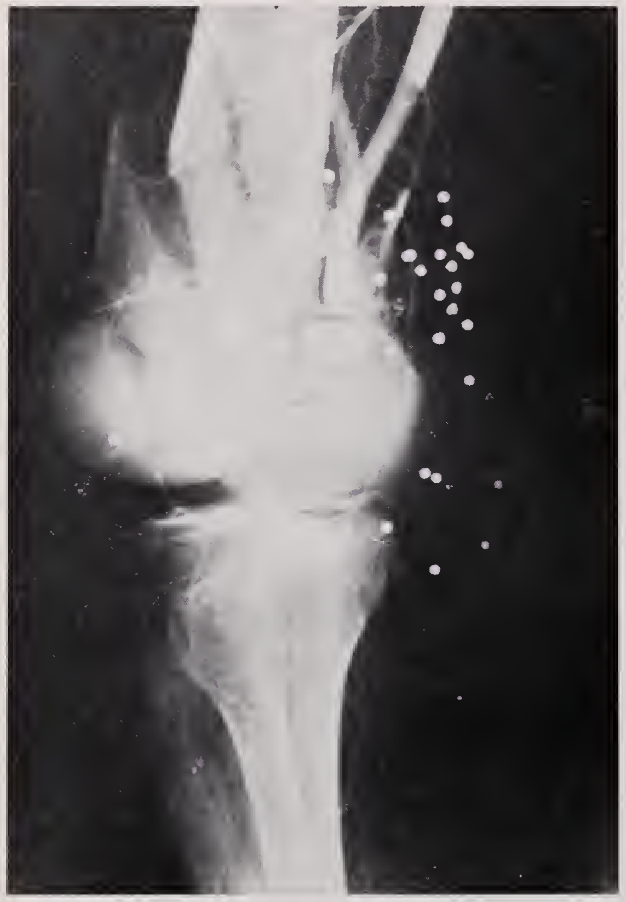

FIGURE I(a): Shotgun wound of knee, arteriogram demonstrating complete severance of popliteal artery.

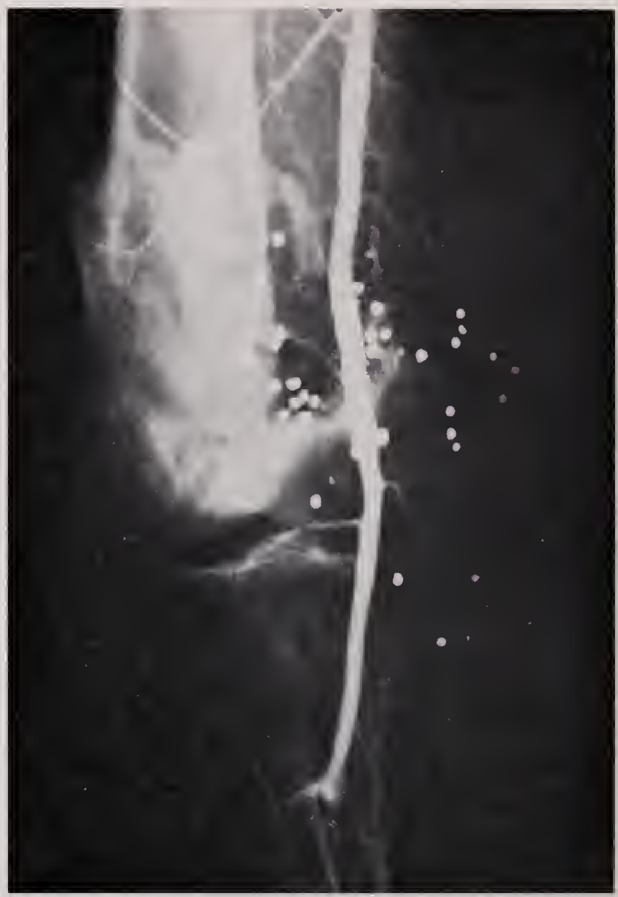

FIGURE I(b): Arteriogram six months after repair of popliteal artery using autogenous vein graft.

TABLE I ARTERIAL EMBOLI

22 PATIENTS	27 EMBOLI
18 MALE	9 FEMALE

AVERAGE AGE 70 YEARS

SOURCE OF EMBOLUS:

HEART	20
AORTA	7

LOCATION OF EMBOLUS:

FEMORAL	16
POPLITEAL	5
BRACHIAL	4
ILIAC	3

TABLE II ASSOCIATED DISEASES

SEVERE HEART DISEASE	14
FIBRILLATING	8
DIABETES	4
AORTIC ANEURYSM	3
COLON CARCINOMA	1
UREMIA	1
ADDISON'S DISEASE	1
STROKE	1
DETACHED RETINA	1
EMPHYSEMA	1

TABLE III RESULTS

RESTORED CIRCULATION	20	(74%)
HOSPITAL DEATHS	6	
AMPUTATIONS	4	

TABLE IV PROGNOSIS

OF 22 PATIENTS:		
DEATH WITHIN ONE YEAR AFTER FIRST EMBOLUS	10	(45%)
OF 4 CASES WHO HAD MULTIPLE EMBOLI:		
DEATH WITHIN ONE YEAR AFTER FIRST EMBOLUS	3	(75%)

The actual surgical removal of the embolus was successfully accomplished with restoration of arterial circulation, in 20 out of the 27 embolic episodes. (74%) Three emboli had been present over 24 hours. Two of them had poor results. (Table III.)

There were 4 patients (15% of emboli) who had amputations and 7 hospital deaths. Of our 22 patients, 10 were dead within the first year after embolectomy. Four patients had multiple episodes. Of these, 3 were dead within a year after the first embolus. (Table IV.)

DISCUSSION

The signs and symptoms of sudden arterial occlusion are well known. They include pain, coldness, and numbness in the extremity, with pallor and mottled cyanosis, usually a definite level of temperature demarcation and a loss of pulses below the level of occlusion. The final end point of viability is loss of motor function of the muscles intrinsic to the ischemic area. The results of therapy are usually dependent on early treatment, for there is always a propagation distally of thrombosis following embolization.

In large collected series of cases, 90-95% of emboli have been found to arise in the heart.[4] Most of the others arise in the aortic aneurysms or severely atherosclerotic aortas. Crane[5] has indicated that one should think of the aorta as a source of emboli in localized ischemia of one or more toes.

IN THE TREATMENT OF arterial embolism, without a doubt the most valuable recent development has been the introduction of the balloon catheter by Fogarty in 1963.[6] There has been a marked increase in successful embolectomies with the use of this catheter. In 25% of patients with embolism, other clots and emboli have been found at a distance from the original embolus.[7] Additional clots and emboli may be present even in the presence of good arterial backflow from the distal vessel. This instrument has also made it possible to remove emboli from major vessels, chiefly the iliac and the aorta, through easily accessible arteries such as the femorals. This may be done with little additional risk and often under local anesthesia. The mortality rate is high in these patients because of the many serious associated diseases, and this simple method often can be employed safely in this poor risk group.

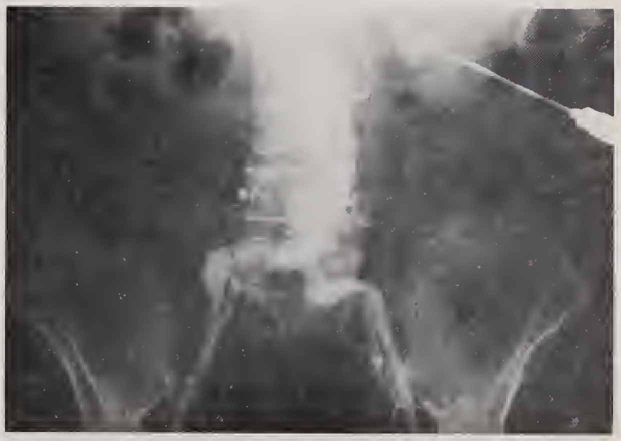

FIGURE II(a): Aortogram before aortic resection for aneurysm.

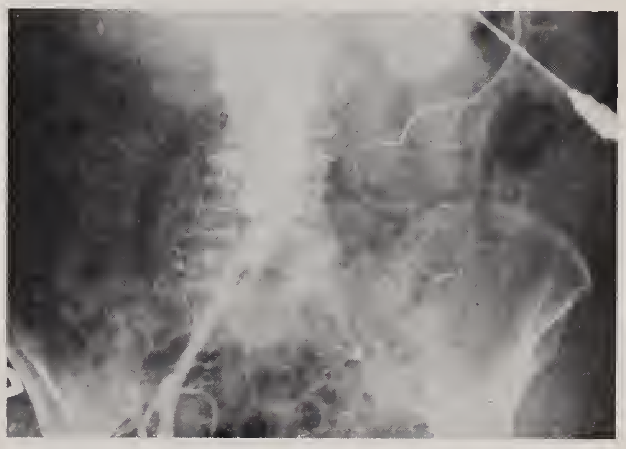

FIGURE II(b): Aortogram one year after aortic resection. Severe kink in right iliac limb of dacron prothesis is demonstrated. Left limb was completely occluded by a similar kink.

Lumbar sympathectomy has been used by us and others after unsuccessful or incomplete embolectomies in attempt to avoid or lower the level of amputation. Its main benefits lie in an improvement in viability of the skin and in some alleviation of rest pain. Most investigators agree that sympathectomy has little effect on claudication.

Anticoagulants should always be used in an attempt to prevent distal propagating thrombosis if there is to be any significant delay in the surgical treatment of acute arterial occlusion. Heparin is the drug of choice and it also used at the time of surgery because of its immediate action. We have not considered its use helpful after restoration of circulation to an extremity which had adequate outflow vessels.

MUCH WORK HAS BEEN done recently on the use of low molecular weight dextran in the treatment of vascular disease and ischemia. We have not had the opportunity to run any significant studies on the use of this material because its availability has been limited until the present year to investigation by a limited number of hospitals. Dextran of a molecular weight of about 40,000 is said to prevent thrombosis in the following ways:

(a.) It increases hemodilution and reduces viscosity.

(b.) It coats the red cells and prevents the adherence of agglutinating protein substances.

(c.) It increases the negative charge of the red blood cells and causes them to repel each other.

It has been found to be safer than anticoagulants because no defect in the clotting mechanism is produced and there is no alternative of bleeding time. Its only real danger lies in the potential overloading of the circulation.

CONCLUSIONS

We agree with the contention that surgical intervention is more effective than conservative therapy in acute arterial occlusion. Other investigators have found that even in viable limbs, after brachial artery occlusion treated only with supportive medical care, 25% have disability due to ischemia and causalgia.

Mortality rates in the treatment of acute occlusion have been quoted at from 20-40%[7] with death usually due to heart disease. Our own mortality rate was 26% with 45% of patients dead within a year following their first embolic episode. In those with multiple emboli, 75% were dead within a year after their first embolus.

The Fogarty catheter has been an indispensible addition to the surgical treatment of arterial embolism and thrombosis. Other new developments, such as low molecular weight dextran, may help to lower mortality and morbidity.

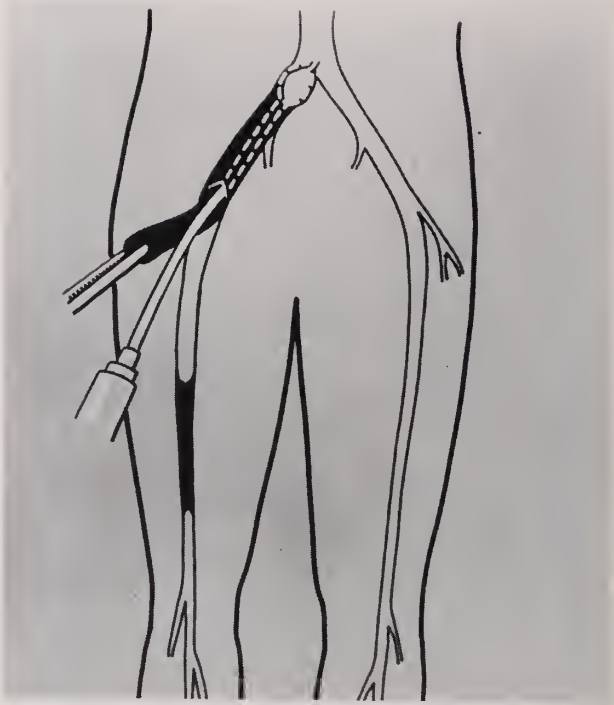

FIGURE III: Diagram illustrating the use of embolectomy catheter for extracting proximal and distal emboli through easily accessible arteries.

SUMMARY

A review of 27 emboli treated in 22 patients has been presented, along with a review of the causes and treatment of acute arterial occlusion.

Most of these patients have severe heart disease and/or other significant disabilities at the time of their occlusion, resulting in a high mortality rate.

Almost half of our patients with arterial embolism were dead within one year after their first episode.

Surgical treatment, with the use of the balloon catheter and other adjunctive measures, is to be preferred rather than conservative management in acute arterial occlusion.

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Editorial Comment:

This article acutely points out the value of surgical intervention in acute arterial occlusion as a limb or life saving procedure, and the obvious value of the Fogarty catheter. It is also obvious the question of sympathectomy has not yet been laid to rest.

One notes that in this group (average age 70 years) of 22 patients with 27 emboli, that a 45% mortality occured within one year. It is also noted that 14 cases had severe heart disease and 8 of these were fibrillating. One wonders whether long-term anticoagulation was used and whether it would have altered the picture.

—John W. Moses, M.D.
Scientific Editor

The Child's Call for Help

ABSTRACT — Clinical examples are utilized to demonstrate how the child calls for help in non-verbal behavioral ways, and further, in ways that are counter to what is acceptable in a given community. The examples have one important aspect in common in that they each tended to force intervention by some outside agency. The need for a community to be alert to such calls and respond promptly, thereby hopefully helping the child avoid the need for "louder" and more forceful and often more dangerous communications, cannot be emphasized too strongly.

BY RAYMOND W. WAGGONER, JR., M.D.
MARSHALL SHEARER, M.D.
BOTH OF ANN ARBOR

A suicide act in an adult is seen as a composite of the impulses to die, to be rescued, to "hurt" another person usually a "loved one," and a call for help. If the likelihood of death resulting from the act is small, it is usually referred to as a suicide gesture, with the "wish for help" impulse being predominant. These adults use this non-verbal means of obtaining help even though they frequently know how to obtain help otherwise.

What is a child to do who lacks such knowledge and sophistication, who finds himself in an intolerable situation with himself and his parents?

How does he call for help?

In our experience it is only at age 14 to 15 that a child can verbally ask his parents, teacher or other adult to secure help for him. Prior to that age he may not have the awareness that any outside agency or person could midify his and his parents interaction, or he is too scared to articulate the problem or cannot do so — perhaps even to himself.

Children must "call for help" in non-verbal behavioral ways. This may take a variety of forms.

IT IS THE THESIS of this paper that the child calls for help in non-verbal behavioral ways and this behavior is most apt to take the form of a community "delinquent" act. At least this is where we have seen it most clearly and most often.

We are not suggesting that all delinquent acts are such calls although they may be, nor are we suggesting that when the call for help is present that there is not also the comprised impulses to direct anger both to the self and to a "loved one." Although this complex is sometimes present and can be seen in some of our case material, we wish in this paper to direct ourselves to the aspect that tends to force interventions by some outside agency. We wish to emphasize the need for the appropriate helping professions to be alert for a behavioral call for help and respond promptly, thereby hopefully precluding the need for the child to attempt "louder" and more forceful and often more dangerous communications.

The cases we see are those in which neither the family nor the school have heard the call and responded appropriately, but have tended to ignore the problem or deal with it by suppression of the overt behavior.

Unfortunately, the child does not know what his community considers a psychiatric emergency (if, in fact, he has any concept of what a psychiatrist is). There is some evidence to indicate that the older child's concept of what constitutes a psychiatric emergency influences his choice of behavior. For example one 12-year-old boy wrote numerous suicide notes and acted depressed. He talked of committing suicide by drowning and once while at the lake said to his parents, "I'm going to walk right out into the lake until it's over my head and keep walking." He did so and was rescued by the lifeguard who pulled him into a rowboat. It was only after he had subsequently announced that he was going to walk in front of a car and did so that his parents sought psychiatric help.

DELINQUENCY IS THE most frequent method chosen by children to gain outside intervention. The single most frequent delinquent act is to steal in a manner to insure apprehension. Stealing is often easy for the child to rationalize. There is relatively little risk of self-injury and other motives can frequently be achieved. One 12-year old boy stole a $200 necklace while babysitting and gave it to his girlfriend to "wear to school" where he knew it would be spotted. Auto theft is also common:

A. IS A 16-YEAR-OLD BOY who had been in several foster homes until he was adopted at the age of 9. He came to the attention of the juvenile court after he had stolen a car, driven it around with a friend and then pushed it in the river. When A. was interviewed he appeared as a tall, thin, nice-looking boy who looked considerably younger than his 16 years. He had a drawn, tense, depressed appearance and his eyes looked as though he might be about to cry. He was quite anxious throughout the interview.

When asked what had happened, he started by saying he could no longer live at his home, that he had to get out because he could not get along with his father. He then said he and a friend had seen a car with the keys in it, gone for a joy ride, parked it that evening and left it. He said he felt certain the police would find it but they did not. He and his friend went back the next day and after driving around some more, and since they had not been caught yet, they felt they ought to push the car in the river. Apparently, someone had seen and recognized A., and had reported it to the police so he was later apprehended.

A. said he did not know why he had taken the car, but when asked about home he again said he had to get out. When asked what might happen if he was returned home, he said "Oh, I might try to rob a gas station or something like that." This was said with a considerable amount of anxiety and was taken as a sincere statement.

The evaluation of the family revealed that the boy's mother had some 15 years ago lost a baby at 3 weeks of age which was to be her only pregnancy. She apparently suffered a severe depression at that time and has clearly never worked through her grief. As she talked about the loss, she became extremely agitated and depressed and her facial expressions denoted intense rage. What became apparent was that she was in effect, attempting to replace her loss with the adoption of A. and attempting to psychologically force him into an infant's role. The situation had become intolerable for A. who in a joint interview with his parents seemed unconsciously and ambivalently trying to be the infant his mother was wanting him to be. In this interview the mother clearly demonstrated that she was totally unable to "hear" A. or respond to his emotional needs.

At the time of the theft, it is unlikely that A. consciously was aware of why he stole the car or for that matter pushed it in the river. Following his apprehension, detention in the Juvenile Detention Home and psychiatric evaluation, however, he was to some degree aware of the implications of his actions. This seemed clear by his statement about robbing a gas station if he were returned home. Interestingly, on a previous occasion some months before, he had written his name on a water tower in a nearby city "because I wanted to see my name writ like that."

There appears to be a strong element of guilt operative in this boy associated with not living up to his mother's expectations. He clearly has attempted to be his mother's grieved, lost "baby" without success. He has repeatedly gotten the message from his parents that in his mother's words, "We hoped he would develop meaningful object relationships but we were wrong." He was at once terribly angry yet needful of his parents. This particular act got him out of the home by being caught for doing "something bad."

In many respects, A., is similar to the adult who feels guilty and seeks punishment by doing something else for which he will be punished, and this is frequently compromized with the hostile wishes toward an ambivalent object, just as occurs in suicide acts.

The following two cases demonstrate this further.

A 7-YEAR-OLD CAUCASIAN boy was referred to Children's Psychiatric Hospital by a child guidance clinic, secondary to referral to them by the police. The chief complaints were lying, stealing, fights, fire-setting, enuresis, belligerance, yelling at mother (I hate you) and calling her a tramp and a slut like his father did. The incident which precipitated the referral was his pulling a knife on the babysitter. (Three years prior to the incident the mother had a "nervous breakdown" and picked up knives and threatened to kill people.) The mother stated he had a bravado, belligerant attitude and repeatedly said, "I don't have to listen to you. I hate you." She reported that she was at her wits end to know how to control him. She had tried to manage him by talking to him and had whipped him with a belt, sometimes on his bare bottom.

He was quite close to his maternal grandmother prior to her developing leukemia and dying in 1966. The parents date the onset of his difficulties to about six months prior to her death which coincides with her lethargy and the diagnosis of leukemia being made.

The mother, age 29, was three months pregnant with the patient prior to her marriage. In 1964 she had a "nervous breakdown" resulting in a series of ECT. Subsequently, she has had three addtional psychiatric hospitalizations for "going to pieces." One of these was secondary to an overdose of sleeping pills. In terms of modesty, the mother stated she does not go out of her way not to be naked in front of the children and that when she does walk into a room naked she tries to convey a nonchalant attitude so the children will not think there is anything to be ashamed of.

The father, a 31-year-old electrician, was married previously. His first wife committed suicide with an overdose of sleeping pills in June prior to his marriage to his current wife in November of the same year. He also attempted suicide with sleeping pills shortly after his first wife's death. He noted their son did not play with fire or soil his pants when around him. Except for enuresis and encopresis the boy is just like his father was as a child, according to his father. The father also would go around the house naked, including standing in front of the picture window, which his wife objected to. He replied that passersby do not have to look if they do not want to. This decreased after the police talked to him about it. At the child guidance clinic, the parents got into a real argument as to whether she had filed for divorce six or seven times. Each parent would "steal" from the other and from the children's banks. The wife took the hinges off his gun cabinet to take 27 silver dollars to pay her Bingo gambling debts. Both also tacitly acknowledged they stole from outside the home also. On occasion the mother would tell the children the father stole the plywood in order to make some favorite toy. Each accused the other of infidelity in front of the children without the other denying it. The patient picked up the mother's accusation of the father sleeping with the "girl next door." He also imitated his father who called his wife a tramp and slut after she was "raped" when she was picked up by a man while walking along a highway. After the rape she coaxed the man to take her to a drug store — where she called the police.

There are two other children, 2 and 4½ years younger.

A school report indicated that the stealing was chiefly a means of getting attention, that his teacher was completely rejecting him. The trait that got to her most was "that silly smile he wears all the time, especially when confronted with his stealing." He was at grade level, doing "C" work. He has a normal attention span and does good seat work.

Psychological testing revealed a guarded, rather than constricted boy who could modulate this tendency in the service of attaining his goals. He lacked flexibility under stress. "It was not possible to state precisely the source of this lack of depth in adaptive skill. One might suspect a very limited experience basis, a deprivation along these lines in the home situation." "In content the tests suggested an incomplete resolution of the first phase of the oedipal complex in rising sexual curiosity. What was suggested was no regression but slowed psychosexual development. He had many concerns about his body and that of others, but this was more curiosity than fear of injury. He pictured home life as disorganized. He was aware of parental struggles, felt helpless, sided with mother but saw her as helpless. She was seen as potentially giving but not doing so. There was a considerable defense structure against the aggression of father."

He responded very positively to a description of the type of hospital CPH was and was eager to explore the hospital.

It appeared that, indeed, he got a great deal of nurturance from his grandmother prior to her illness and that a good deal of his behavior constituted an imitation of his parents, as he was caught in a real conflict between his warring parents. This state was chronic. The call for help was his pulling a knife on the babysitter.

M. IS A 13-YEAR-OLD, handsome, slightly overweight boy of superior intelligence who was referred to CPH by a psychiatrist because of refusal to go to school and repeated physical attacks on his mother during which he had inflicted painful bruises, and due to his apparent lack of control and evident rage, had quite frightened his mother. This had gone on for about two months prior to referral to CPH.

His 17-year-old brother had to intervene on more than one occasion to prevent serious physical injury to his mother. The boy's parents are divorced and at the time he was seen — the boy was temporarily living with his father because of the family's concern of injury to the mother.

M. had done well in school and had shown no overt evidence of conflict until approximately one year prior to referral. At that time he began refusing to go to school because of "stomach aches." (Interestingly, the mother had a 15-year history of colitis with frequent complaints of abdominal cramps.) He would then stay home on some occasions or on others return from school after calling his mother to pick him up.

This developed to the point where he entirely refused to go to school. Pressure from the school resulted in a number of examinations by physicians over the year, including four psychiatrists. Attempts to physically force him to school resulted on one occasion in the father being kicked by M. in the testicles which promptly halted these efforts. After that he would sit at home watching T.V., help his mother with housework, prepare dinner and help with washing the dishes after dinner.

Frequently he would go to his mother's bedroom after she had gone to bed either to have his back rubbed or to rub his mother's back. He noted his mother was a very neat housekeeper except that "her room is always a mess." He had often slept in his mother's bed since his parent's separation and subsequent divorce (this had occurred some five years prior to the evaluation). It finally developed that if his mother would attempt to keep him out of the bedroom on the recommendation of the physicians she had seen, he would become violently angry, kick at the door, try to force his way in and it was usually at these times that the attacks on his mother would occur. The mother noted that she had been told he was suffering from an "Oedipal complex and I should completely reject him."

The parents had had marital conflict for a number of years and were divorced as was mentioned above, five years prior to referral to our clinic. M. had lived with his mother since the divorce and was visited two to three times a week by his father. The mother was seen as a very angry, depreciating woman who showed a high level of anxiety and what appeared to be a chronic depressive state. She had marked dependency needs which she was unable to get fulfilled. After her husband left, she allowed M. in essence, to take his father's place, often allowing and encouraging him to sleep with her at night. Neither M. nor his mother were able to handle his impulses as he moved into puberty.

At the time of evaluation, it became clear that the situation existing between the mother and M. was of crisis proportion and that immediate intervention in the form of removal of M. from the mother's home was essential to prevent serious injury to the mother.

The question of conscious versus unconscious motivation in these patients should be mentioned. Usually there seems to be some conscious awareness or at least a preconscious awareness of what the symptom is accomplishing by the time of psychiatric referral.

The following is a case history of a "second" call for help when the first resulted in treatment which did not meet the child's needs or expectations. The unusual feature here was the child's awareness of available help and what the child guidance clinic would consider as emergent for the second call. This was apparently due to her knowledge of her father's duties in religious work. It is felt her "second call" was conscious and deliberate.

W. IS AN 11-YEAR-OLD white female, referred to CPH from a child guidance clinic with the chief complaint of delusions. She had been refer-

SHEARER

CO-AUTHORS

The co-authors, Doctors Waggoner and Shearer, presented this paper at the Research Symposium on Psychiatric Emergencies at the University of Michigan Medical Center, October 5-6, 1967.

WAGGONER

red to CPH from a child guidance clinic with the viously by her mother with the chief complaint of, "she has no friends."

Both parents are middle age and college graduates. The father is employed full time in religious work (not a minister). Many evenings and weekends he is not available to his family. He gets "kicks" out of outmaneuvering other drivers in traffic and running red lights. He does not follow many teachings of his church in daily living, although he professed to do so. He intellectualizes frequently. The mother described her own childhood as one of conflict with her own mother — "Mother never said what she really meant." The patient and her mother occupied the same position in their respective sibship.

The patient's early developmental history was unremarkable except for difficulty in toilet training and stubborness.

At the child guidance clinic, beneath the veneer of a mother seeking help for her friendless daughter, was a hostile mother who spoke of the patient through clenched teeth. The patient had a mind of her own, would not obey (i.e. coming home from school a half hour late, refusing to help around the house, not taking piano lessons). The mother complained that the patient sang off key, "She is obese and our doctor doesn't like fat kids. She has no poise or social grace. She walks and looks like her father." (Mother was a Girl Scout leader and said the patient had no friends among the Scouts.) Compared with her talented, gracious, achieving sisters, she was second best although an A-B student. Her dress and general appearance was more appropriate for an 8-year-old than a girl of 11.

She was wearing her Sunday clothes on a Friday (which the parents said was "intolerable"), was poorly groomed especially in church, had taken to making facial grimaces in church, and picking her nose and eating it at home and in church. Lastly, she had begun to talk of death, dying and running away.

On investigation, she did have friends. Most of them were boys and her play was tomboyish.

At the child guidance clinic things got worse after a brief time. Her drawing shifted to only heads of women and boys with skirts. She began exposing her panties in the office and at length talking about a snake in the filing cabinet that was going to bite her, and saying she could talk to God. She said God told her his real birthday was December 13, and he was coming in the year 200—a fact she was to publicize. The child guidance clinic became quite alarmed and referred her to CPH for inpatient treatment.

At the time of referral she was seen to be depressed. She also had an extensive fantasy life with some question of her control of it. Her two fantasy themes were being a deserted waif and rescued by a prince charming and of people being secret agents to spy and find out what others thought of her and report to her. By the end of the interview she was relating quite well.

The mother was relieved at the recommendation of inpatient hospitalization.

On admission, she carried a small jewelry box with a small piece of yarn protruding. It was her "transistor" which allowed her to talk with the "Jolly Green Giant" and with "God." She was about to leave this in the doctor's office when her mother reminded her of it.

The first progress note was written after one and a half weeks. "The patient impresses me as anything but a psychotic youngster and I am hard put to believe she is actually hallucinating or delusional, even in the past. Rather, I feel that she has used her pseudo-delusions as manipulative devices to restructure and influence her environment and this to a great success. She indicates that she was eager to terminate her relationship at the child guidance clinic because the hope for changes in the relationship with her parents was not forthcoming. At this point, even knowing or sensing her therapist's sensitivity to this particular kind of behavior or production, she (best as I can tell) feigned hallucinatory and delusional experiences in order to sever the relationship. She was successful in doing this. In spite of her verbal protests and playing the role of not liking it here at CPH, it is rather obvious she is enjoying her involvement in her activities with me." She does grimace at time and her attitude toward feminine staff varied from normal to one of stubborn rebellion or infantile clinging.

Later the basic dynamics emerged. The mother was quite ambivalent toward the patient's emerging sexuality. On one hand, mother was fearful her daughter would be too attractive to boys and act out sexually, hence the clothes inappropriate for her age and general parental attitudes and restrictions commensurate with that younger age.

On the other hand, in subtle, undoubtedly unconscious ways, she was encouraging her daughter to act older than her age. The parents had a poor sexual relationship and the mother was seen as having a "super ego lacunae" in the sexual area with the fear of her daughter's sexual involvement yet vicariously enjoying the thought of it.

THE CASES THAT we have seen have a long history of chronic conflict between the child and usually one parent with the other parent either being psychologically not involved or supportive of the conflict in indirect ways. The child may, in fact, be acting out the parent's unconscious needs. At the time of a clear "call for help" this chronic conflict usually has taken the turn for the worse, which though not necessarily too marked, is obviously significant if recognized. There is, of course, the new symptom or behavior which constitutes the call for help also.

Often when the child is interviewed alone he has more insight than his parents and is greatly relieved at the intervention and especially at the prospect of treatment.

The denial one sees in parents in these situations is usually considerable and must be dealt with actively and directly. Sometimes the goal in regard to the parents, that must be settled for is helping the child understand his responsibility and part in what is happening and to guide him to make the best possible adjustment to a difficult home situation.

In this paper we are not suggesting that all deviant behavior is an unconscious call for help. What we are proposing is that there is a group of cases in which the symptomotology is based on the child's unconscious or almost conscious desire for help.

We also feel there are implications for treatment, establishing a meaningful rapport with the family at the time of the first contact, but most important is heeding the call the first time, wherever the call arises so that the child is not pushed to even greater and more dangerous measures to attract and sometimes force outside intervention and assistance.

Survival Patterns for Small Hospitals —Dilemmas and Prospects

BY ANDREW PATTULLO, M.B.A.
BATTLE CREEK

This opportunity to discuss the future of smaller hospitals is very gratifying. One reason has to do with the Kellogg Foundation and its earlier history. For its first 10-15 years of existence (1930-1945), the Foundation was primarily known in the hospital field for its activities with smaller hospitals in Michigan. In the "Michigan Community Health Project," the Foundation worked extensively in seven predominately rural counties of Southwestern Michigan and dealing with all aspects of health—preventive and curative.

It soon became obvious that hospitals were essential to this total program, but the resources at that time were rather minimal. For example, several hospitals were situated in converted "mansions." As Graham Davis, the Foundation's first hospital staff person used to say, the hospitals were "pretty sorry." Hence, the Foundation endeavored to help in many ways, ranging from support for completely new, "model" hospitals, to broad educational programs. As a matter of fact, one of the first non-metropolitan hospital councils in the country emerged from that program, the Southwest Michigan Hospital Council, noted for progressiveness and its sponsorship of the Professional Activities Study.

At that time (circa 1940) a considerable controversy raged in this country concerning the role of small hospitals. (And times haven't changed too much.) The question primarily hinged on "to be or not to be." A number of knowledgeable people maintained that is was much better to concentrate hospitals in fairly large communities, and not to build facilities in rural areas. The Foundation's position was substantially to the opposite pole, that in fact hospitals were essential to the attraction of physicians.

Several of the model hospitals the Foundation helped to construct were in collaboration with the Public Works Administration, a federal program designed to combat the depression. In 1940, the magazine *Hospitals* carried a lead article attacking the government and the Foundation for the development of such hospitals, maintaining they were a disservice to the American people.

SOME YEARS LATER in the mid-40's there still existed a real gap between many smaller hospitals as contrasted to sister institutions in larger cities. At that point, the Foundation extended a program in diagnostic services improvement initiated in Southwestern Michigan to the balance of the state, including the Upper Peninsula, where in 1946 there was not a single pathologist and only one radiologist to serve this large region.

I shall never forget one experience in a prosperous county-seat hospital when the board President was showing me around. With some pride he opened a door saying, "This is our X-ray Department." It opened into a closet containing a portable X-ray machine. Incidentally, today this is now a fully accredited hospital of some 150 beds, beautifully staffed and equipped. The original rationale of Hill-Burton was to bring improved hospital care to rural America. It is now generally acknowledged that the Act really went too far, since undoubtedly in some states too many hospitals were built in locations where they probably shouldn't have been. And yet, readily admitting these deficiencies, Hill-Burton put the small hospital "in the sun."

Because of a massive and unique federal program, the existence of the small hospital in this country is no longer a theoretical matter. There are literally thousands. But even so, the role of the small hospital is still very much a matter of concern.

Small Hospitals Have Major Problems

Using such criteria as Productivity, Costs, and Quality, small hospitals have major problems, probably more so than in much larger institutions. For example, there is still a significant gap in terms of meeting accreditation standards of the Joint Commission. There is a definite correlation between size and accreditation — the smaller the institution the less likelihood of accreditation.

The small hospital has often been the target of charges that it is basically an uneconomical and inefficient operation. This thesis probably stands up better in the case of small hospitals in urban

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Mr. Pattullo is Director, Division of Hospitals, W. K. Kellogg Foundation, Battle Creek. The article is printed with the permission of the Michigan Hospital Association, which printed it originally in its journal.

areas, where the desirable minimum size is generally looked upon as being 200 beds. In cities, the small institution is difficult to defend on the basis of plant and service duplication. But in many instances the small hospital is a single institution serving a community and surrounding area. Two hundred beds may or may not be desirable, but in most cases it is somewhat theoretical.

STILL ANOTHER CONSEQUENTIAL problem confronting small hospitals is manpower. As noted, most such hospitals are in non-metropolitan areas, and of course are not teaching institutions. Hence the attracting of skilled personnel is usually troublesome.

In 1967, as in previous years, the smaller hospital is under attack. The title of this presentation "Survival Patterns" is good proof of this. There have been dramatic changes in the small hospital over the past two decades. But there are still basic weaknesses inherent in the small hospital which must be resolved. "Survival Patterns" is a provocative way of putting it. Any examination of recent events reveals a deep concern about the community hospital.

One evidence of this is found in the DeBakey report, in turn followed by the Heart, Stroke, and Cancer legislation. The thrust of this report and Act has to do basically with the "performance gap" between the excellence in the great teaching medical centers (as exemplified by the *Ladies Home Journal's* "ten best") and something less presumably found in most other institutions. Although there may be some skepticism in terms of the actual implementation of Heart, Cancer, and Stroke, as resulting in the "haves" getting even more, the objectives are quite different—the "have nots" are supposed to benefit too.

Another compelling indication is found in hospital areawide planning, and now also in comprehensive health care legislation. Although areawide planning may have had its genesis in terms of self-protection on the part of major groups and corporate givers in such major population centers as New York, Chicago, and Detroit, its implications soon out ran this orientation. At this point no one can prophesize the total impact of comprehensive planning, but it is bound to influence the small hospital. How could it do other, since the hospital is the keystone of community health services, and the small hospital is at least numerically far in the majority?

STILL ANOTHER POWERFUL factor in the situation is the physician, at least in terms of the quality gap. Twenty-five years ago we were talking about the necessity of the hospital in smaller communities as essential to the attracting of doctors. Today the doctor who has been attracted is more and more insistent that to the greatest extent possible he not be isolated, that he have available services reasonably compared to the medical center where he was trained. This is why he wants an intensive care unit, and today, even in a 40-bed hospital, talks about a coronary care service and an image amplifier in X-ray. Sometimes these demands may not appear to be too practical, but they are symptomatic of a very real desire of the physician to be provided with what he believes to be essentials.

A generation ago the small hospital medical staff was much more apt to be satisfied with what was available. For example, the absence of even minimal diagnostic X-ray and laboratory tools was accepted, perhaps with resignation, as a fact of life in rural practice. Today's young doctor is not going to accept it.

Still another dimension is administration, admittedly an aspect of some sensitivity and delicacy. A generation ago the typical small hospital administrator was a nurse, who was usually moved up from a clinical supervisory position. Most of these nurse-administrators were sincere, hard-working, and "dedicated," as overworked as this cliche may be. A number were also efficient, able, and "hardheaded" business-wise.

In the mid-1940's hospital administration was becoming recognized as a profession; and several university graduate programs were being established. Inevitably this has had an influence upon the small hospital. Today the nurse-administrator is almost a rarity; the male is predominant. The typical board of trustees recognizes the hospital as a complex undertaking and now looks for a "business" type of executive. And more often the new breed is likely to be a young university course product, who usually views the small hospital as a first rung up the ladder.

This administrator is something like the young M.D.—he, too, wants an institution of excellence. Through regional and state hospital meetings and the other ways he keeps in touch with developments—he is not as isolated as his predecessor of 1930-1940. Selfishly, in terms of his own career, he must be associated with a hospital that is accredited. He is looking for better solutions to the problems of the small hospital. And my observation is that although he originally looked upon his job and hospital as a stepping-stone, he finds so much satisfaction he is tending to remain and grow with the hospital.

WITH ALL THESE factors—such as Hill-Burton, areawide and comprehensive health planning, medical staff, and administration—the small hospital of today is much different. But we are on the threshhold of still further changes that will be even more consequential in the coming decade.

To accomplish these, some degree of "autonomy" of the individual hospital will be lost, but I believe the new era will be one of real excitement and challenge. It will require a degree of cooperation not yet realized in the hospital field, but it will result in a very much improved level of service to the people.

"Compact" Agreements. Only within the past 20 years have state hospital associations come into their own. Within that span most states have retained full-time executives, and many have mounted imaginative and extensive programs. In the next decade we shall see similar developments on a regional level but with a somewhat different orientation. Present hospital "councils," often a pleasant luncheon club, will retain full-time executives and staffs. The program emphasis will be concerned with the development of what I will term "compacts," to which member hospitals may or may not subscribe. The trust of such compacts may be described simply as providing on a cooperative basis such services as an individual hospital would find it very difficult to undertake alone. Following are examples:

Computer Applications. The hospital world is on the threshhold of significant breakthroughs in terms of computer applications. At this point they are still very much developmental, but the potential is there. As I grasp it, if any two factors about computers are accepted they relate to (1) size of capability in terms of output, and (2) to the fact even the simpler applications are extremely expensive to implement. There is every reason to believe it would be very much to the individual hospital's advantage to join forces for computer application. By so doing it would be possible for the single hospital to have access to hardware of a capability impossible to acquire by itself. In terms of programming expense, this would also be shared with many others. This would necessitate agreements as to participation, and to sharing capital and/or operating costs.

It does not make sense for all but perhaps a very few large and unique hospitals, mainly university connected, to install individual computers. Unfortunately there is very apt to be a large amount of money expended by individual hospitals for computer installations, probably largely wasted, that could much better be pooled for better results.

Thus the small hospital probably cannot by itself think of an individual computer, but it definitely can in cooperation with others. The potential of the computer is literally breathtaking, and will do much to bring all hospitals—from medical center to the smallest unit—together. Further, the eventual application will likely be extended from the hospital to the individual physician's office to provide an even greater degree of integration.

It is, however, not now premature for the small hospital, *in cooperation with others,* to take initial steps in the formation of "compacts" for computer development. It would be well to seek expert advice; in the Tri-State area the University of Michigan is an excellent resource with some experience already gained in the hospital field.

"Management" Engineering. I do not know of any research that has conclusively demonstrated smaller hospitals to be more inefficient or costly than larger institutions, except possibly those small hospitals located in large, urban areas. I do not believe this to be the real issue. But large or small, hospitals are under continuing and harassing attack in terms of productivity and costs. It stands to some reason that smaller hospitals do have greater problems in regard to these questions because of their comparatively limited resources in terms of plant investment and operating capital.

I believe that all hospitals must become more concerned with these questions. But perhaps small hospitals have a more difficult problem in coming to grips with them than do larger institutions. But there are ways and means for any hospital to adopt something other than a passive attitude. For example, "HAS" and "CAP" are ongoing national programs very much concerned with productivity and costs, and which came into being mainly for the benefit of smaller hospitals in this country. Their cost is reasonable; there is no excuse for any hospital not participating. In another area the same case stands for "PAS" and "MAP" related to patient care studies and practices.

In my ken we are also on the threshhold of some kind of similar breakthrough in regard to so-called "management engineering," or the application of industrial engineering to the hospital environment. Some regional councils have already taken steps to bring the benefits of industrial engineering to the individual institution. Results have varied, but in at least one area, Southern California through the CASH program, results have been substantial. CASH was not conceived as a crash effort, but represents a combined practical research, service, and educational venture. Its 140 plus member hospitals, most relatively small, contribute on a prorated basis, and receive value considerably greater in terms of cost reductions, greater efficiency, and yes, improved standards. Another very successful cooperative program is being conducted in Maryland.

Here is another example of the relative impossibility of an individual small hospital being able by itself to obtain the skills of industrial or management engineering. But cooperatively it is possible, as CASH is so well demonstrating. Again, improving productivity and stabilizing costs are two of the major problems in hospitals today. Management engineering is a technique that is available and does have validity in the hospital setting—including direct patient care. Where through a joint approach its benefits can be brought to the smallest hospital, the field is vulnerable to justified criticism if it does not act.

Education and Manpower. The small hospital, through the regional council or the health planning group, must take more postive steps to help itself in resolving manpower problems. And through the exploding community college movement, now at the rate of one new college weekly, there is considerable promise. The community college is very much interested in meeting the technical personnel needs of the area it serves. Although the college may consider its obligations primarily on a local community level, there is no reason why the scope cannot be expanded to a regional basis.

Councils should evaluate their manpower needs on a continuous basis; how many nurses, aides, X-ray and lab technicians, et al, are presently needed and will be in the future? Within an area of 10 counties perhaps only one program in some fields should be offered to meet the needs; in others perhaps two or three could be justified as based on likely demand. I believe those colleges within the region would be very willing to participate in such an approach.

The possibility of multiple area financing should be considered. In interstate regional education compacts, such as SREB, there is a sharing of the cost of certain very expensive professional programs. In terms of intrastate regions perhaps the same principle could be developed, with districts contributing. For example, a compact to finance an expensive A.D. nursing program might be spread among several educational districts, within a given hospital council region.

Television. There is currently a very limited number of experimental TV programs, mainly educational, linking several hospitals. Although the present cost is such to be almost prohibitive except as demonstrations underwritten by outside financing, at some point it will be feasible. In education, airborne television has been in use for several years. TV undoubtedly has great potential for hospitals as well.

In West-central Michigan a group of hospitals, spearheaded by smaller institutions, has been exploring TV linkage for some time. The medical staffs are keenly interested, as a means of communication with medical centers. Other benefits in addition to educational values have been documented by this group. A regional TV compact arrangement is being proposed, beginning with a limited number of participants.

Similar to computer networks, TV arrangements will be regional in nature at first, and then linked to other networks in a state, and possibly interstate as well. Although again education is a principal objective, other uses, e.g. direct patient service, will be possible.

Central Services. The field is very gradually moving to the sharing of certain services and facilities, even where the participants are widely separated geographically. A prosaic illustration is the laundry, where across the country a growing number of groups are now active. Many other kinds of arrangements to share facilities and equipment will be developed. It is believed that a central laboratory service using very costly equipment for many procedures is quite feasible, and will reduce costs substantially while improving and standardizing procedures. Such centralization also contributes to a pooling of skilled and scarce personnel.

Equipment is now available which is said to be capable of processing as many as 2200 blood tests daily, with one or two technicians. A skilled analyst using manual methods might complete a similar volume of work in several weeks. Here again the single small hospital could not justify such equipment, nor would it by itself have this much volume to even warrant consideration. But by combining many hospitals, volume of course is achieved, through which economies can be obtained.

Organization and Administration. Still another logical compact arrangement will be developed involving basic organization and administration of several hospitals. This relates to two or more hospitals, geographically separated, entering into an agreement to share an administrator, and from that point other personnel and services. There is really nothing new about this thought, and there are existent a few examples across the country. But the benefits are so obvious it is difficult to understand why there aren't more. One apparent difficulty has to do with that old shibboleth of hospitals—autonomy. But there is no reason why this should be a real barrier if the arrangement is appropriately and mutually developed.

Previously I said that the key to "survival" lay in compacts such as mentioned, but also stressed the importance of regional hospital council staffing. For unless the latter occurs, the kinds of programs described will be much more difficult to mount, and longer in activation. This means a willingness of hospitals to increase substantially their organizational dues to a point possibly greater than the combined national and state. The executive head of the organization must be as fully qualified as the state director.

It will be his responsibility to help in the shaping of new approaches to cooperative ventures.

Entirely aside from the joint programs involving multiple hospitals, there is one other significant and I believe highly desirable factor that will greatly influence small hospital development in the future. This is a step that will involve most hospitals in a new type of service, and one that will be of substantive benefit to the community. But aside from these aspects, it will have considerable economic implications.

This relates to the hospital's assuming direct responsibility for long-term care as an integral part of its operation. One of the critical problems of small hospitals is its limited economic base. Already discussed has been the multiple or compact approach, which in itself broadens each unit's capabilities. But the addition of long-term care beds is a practical way of not only meeting an acknowledged community and social need, but also strengthening the whole economic structure of the hospital enterprise. It will be possible to spread costs across 80 beds vis a vis 40 acute alone, and so on. Admittedly, this is on the premise that reimbursement under Titles 18 and 19 will be adequate; my assumption is that this will be so.

MY BELIEF IS THAT there will be a very rapid extension of the hospital into the long-term care field. The term "small hospital" will eventually only be a relative term, as likely the typical small hospital will be at least 100 beds. And another development I predict is that in many of these hospitals the acute section will be in the minority. This will call for quite an adjustment in our thinking as to what represents hospital care and services.

Perhaps these comments have covered too many aspects of the small hospital—its dilemmas and prospects. To be sure the small hospital does have some unique and frustrating problems. But the small hospital has never had a more promising and truly exciting future. The isolation and insularity of the past are rapidly disappearing. Through a combination of many forces and influences hospitals will be linked together in numerous ways. The acknowledged gap between the large, urban hospital and the small institution will be substantially erased.

Through computer and television networks (and I suspect other devices today unknown) hospitals will be brought together in a fashion that will truly "regionalize" medical care, from the local physician's office to community hospital to regional center to university teaching complex. Many services will be combined involving hospitals widely separated geographically. The community hospital itself will be numerically larger in the sense of total beds, as it embraces long-term care on an extensive basis. It is difficult to identify any opportunities in the field that will be more challenging, interesting, and provocative than those related to the small hospital. To borrow a phrase "This is where the action will be."

Lateral Abdominal Tenderness: Spigelian Hernia

ABSTRACT — The case of a 39-year-old male with a two-week history of vague right lower quadrant pain is presented. Surgical exploration revealed a hernial orifice that contained a Richter's hernia in a Spigelian location. A necrotic area of the anterior cecal wall was found. The necrotic area of cecum was resected and repaired with a two-layer closure. The hernial orifice and surgical incision were closed in a transverse fashion.

BY MARTIN BEARD, M.D.
FLINT
A. VELANDER, M.D.
MINNEAPOLIS

Lateral ventral hernias generally cause no difficulties in diagnosis and are seen with moderate frequency. The greater percentage of these are inguinal or femoral hernias. A more unusual hernia is the spontaneous lateral ventral hernia — Spigelian hernia — that appears to be reported with increased frequency in the recent literature.

During the past year, one case was seen at the Minneapolis Veterans Hospital. This case is reported below.

CASE REPORT

L. V. Y., MVAH:

A 39-year-old white male was admitted to the Surgical Service of the Minneapolis Veterans Administration Hospital on 9/19/66 because of right sided abdominal pain of two weeks duration. The abdominal pain had become worse on the a.m. of the date of admission. There was no history of jaundice, dark urine, clay colored stones or melena. There was no history of recent abdominal trauma.

The patient did admit to fatty food intolerance and frequent belching following the ingestion of cabbage. Several days prior to admission, the patient had helped in the roofing of a house.

Past history revealed that the patient underwent an appendectomy as a child, had a subtotal gastrectomy at age 23 for a gastric ulcer and had been examined for back pain. Normal cholecystogram was demonstrated one year prior to admission.

The initial laboratory data showed the following: Urinalysis - Normal; Sugar - 0, Albumin - 0; Hematology - WBC - 18,300, neutrophils - 89, lymphocytes - 11, Hbg - 14.0 gm.%; BUN - 8 mgm.%; Bilirubin - total 0.5 mgm.%, direct 0.1 mgm.%; Stool Guaiac - Neg; Serum amylase - 58 units; Prothrombin time - Normal.

Physical examination: B.P. 134/80, Temp. 99.4 (0), Pulse - 84/mm. Well developed and well nourished male.

Positive physical findings:

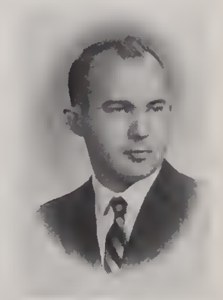
1. Healed left subtotal gastrectomy incision.
2. Healed McBurney's type incision of right lower quadrant.
3. Point tenderness and pain just lateral to right rectus muscle, but medial to old McBurney's incision.

The pain persisted after a period of six hours while the patient was put on nasogastric suction. There was no radiation of the pain and it was more severe with straining and standing.

The patient was taken to the operating room on 9/19/66 and through a transverse incision, the skin and subcutaneous tissues were incised. A small area of induration measuring 2 x 2 centimeters could be palpated adjacent to the right rectus muscle, but medial to the old McBurney incision. The indurated area reduced into the peritoneal cavity under relaxation due to the general anesthesia. A transverse defect was present in the lateral musculature with preperitoneal fat, transversalis fascia and peritoneum protruding through the separated muscle bundles. The peritoneal cavity was entered and a necrotic area of

THE AUTHORS

BEARD



VELANDER

Doctor Beard, formerly with the Department of Surgery, University of Minnesota and the Minneapolis Veterans Administration Hospital, is now in practice in Flint. Doctor Velander is a resident with the Department of Surgery, University of Minnesota and the Minneapolis Veterans Administration Hospital.

the anterior cecal wall was noted. The necrotic area of the cecum was removed and the defect closed in standard two layer fashion. Palpation of abdominal wall was negative. The small and large bowel were examined, the abdominal cavity was irrigated, and the abdominal wall was closed by approximating the peritoneum and transversalis fascia in one layer and closing the fascia, subcutaneous tissue and skin along the line of incision.

The patient developed a superficial wound infection postoperatively, but this healed without consequence.

DISCUSSION

Adrian Van Der Spiegel, (Figure 1) a disciple of Fabricus, was the first to describe the linea semilunaris. An early work of Spiegel's contains this description (Figure 2).

The first to recognize a hernia of the linea semilunaries was probably La Charesse, but this hernia was considered to be traumatic in origin.[5] Klinkosch presented the first vivid description and first located a spontaneous lateral ventral hernia of the linea semilunaris.

Anatomically, the linea semilunaris extends from the ninth costal cartilage, in a curved manner, on the anterior abdominal wall to the pubic spine. It marks the lateral boundary of the rectus abdominal muscle.

There appears to be some confusion as to what constitutes Spiegel's line. Watson states that the linea semilunaris is formed by the aponeurosis of the internal oblique at its point of division to enclose the rectus abdominis muscle.[4] River feels that the linea semilunaris is the transition between the muscle bundles of the internal oblique and the

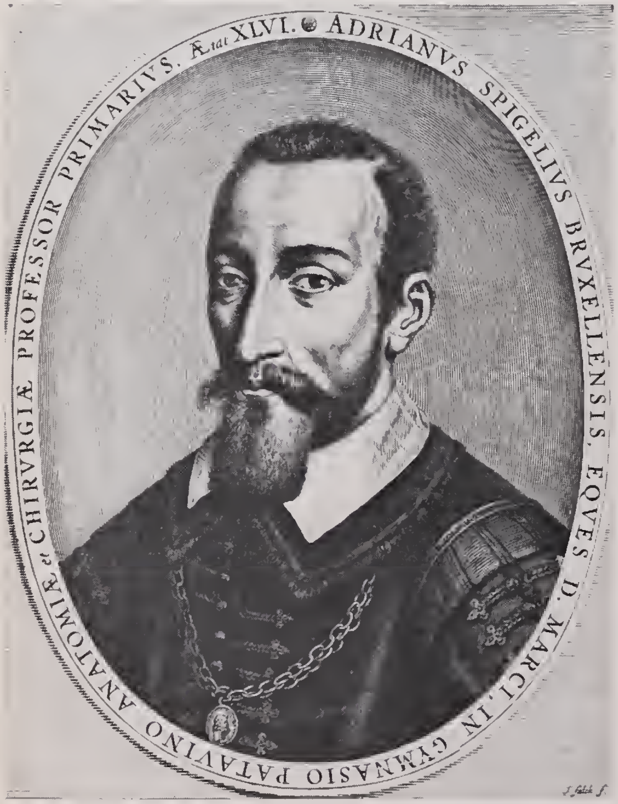

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FIGURE 1. Adrian Van Der Spiegel (1578-1625) was born in Brussels; he studied and taught at Padua between 1618 and 1624.

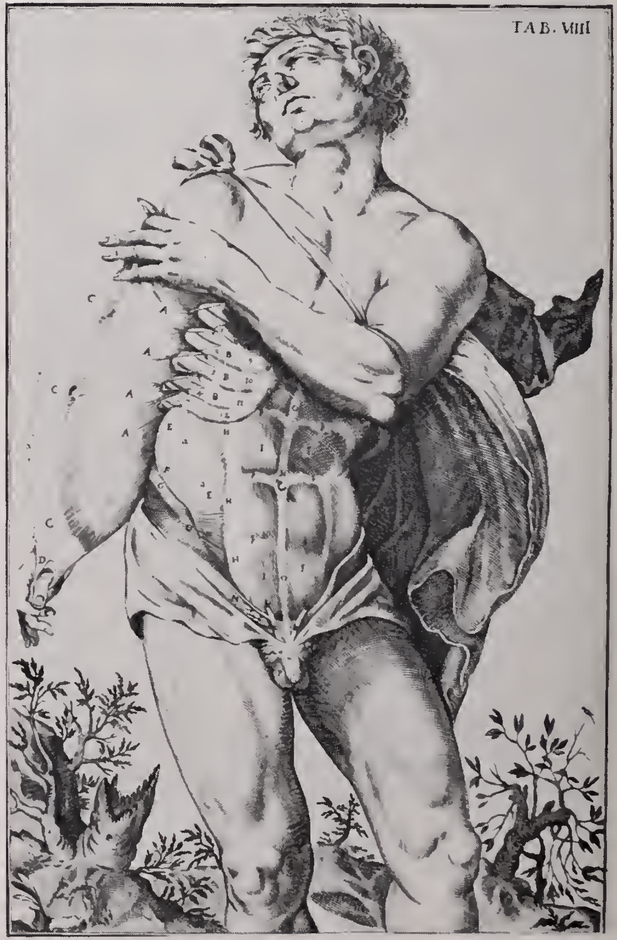

FIGURE 2: HHH-Semilunar line named by Spiegel. The tendons of the oblique muscles of the abdomen begin here.

TABLE I

Defects Found in Internal Oblique Aponeurosis
(Taken from Zimmerman, Anson, Morgan, and McVay)

No. of Defects	No. of Cases with Defects	Percentage of Total No. of Cases (500)
1	74	14.8
2	32	6.4
3	3	0.6
Total	109	21.8

TABLE II

Defects of internal oblique and transverse abdominus aponeurosis alone or together and superimposed as found in 100 body halves. (Taken from Zimmerman, Anson, Morgan and McVay)

Defects	No. of Cases	Percent of Cases
a. One or both internal oblique and transversus not superimposed.	45	45
b. Internal oblique alone.	25	25
c. Transversus alone.	10	10
d. Internal oblique and transversus superimposed.	6	6
e. Transversus cranial to that in internal oblique.	4	4
Total	100	100

aponeurosis of the same muscle.[6] This places the line lateral to the border of the rectus muscle. In practice, Spiegel's line is a broad band[3] and is referred to by some writers as Spiegel's fascia.[5]

The most common site of Spiegel's hernia is below the umbilicus along the lower one third of the linea semilunaris. The muscle fibers of the transversus reach behind the rectus in the upper two thirds or three fourths of the line. This probably accounts for the rarity of herniations above the umbilicus.

Factors that favor spontaneous lateral ventral hernias are obesity, paralysis, multiple pregnancies, emaciation following obesity, chronic cough, straining or increased intra-abdominal pressure from any source. Cooper feels that protrusions occur through perforations that transmit vessels when these orifices are of unusual size or enlarged during a relaxed state.[8] Some writers report the importance of the weak spot that exists where the semilunar line crosses the fold of Douglas[4] (Figure 3). River has described slit-like defects in the aponeurosis of the transversus as it passes forward and fuses with the internal oblique.[6] Some authors ascribe great significance to the lateral branch of the inferior epigastric artery transversing one of these defects.[6] The orifices are described as being 0.5-0.2 cm. in size and seldom larger.

Zimmerman, Anson, Morgan and McVay have shown that the inferior medial extent of the internal oblique and transverse muscle sometimes consists of interdigitating muscle fibers separated by weak aponeurotic structures through which herniations occur. Their findings are shown in Tables I and II.[13]

As shown in Table II, defects in the transversus and internal oblique aponeurosis were superimposed in 6% of the body halves. This allows for potential herniation in this 6% of cases.

The explanation of Zimmerman et al appears to best explain the anatomical basis of the lateral spontaneous ventral hernia since blood vessels do not accompany the hernia orifices with any consistency and there does not appear to be any one site of weakness where the herniation occurs.

Spigelian hernias occur in both sexes with equal frequency and are more prevalent in the fifth and sixth decades.[5] Since January, 1958, 2541 inguinal hernias and only 6 Spigelian hernias have been

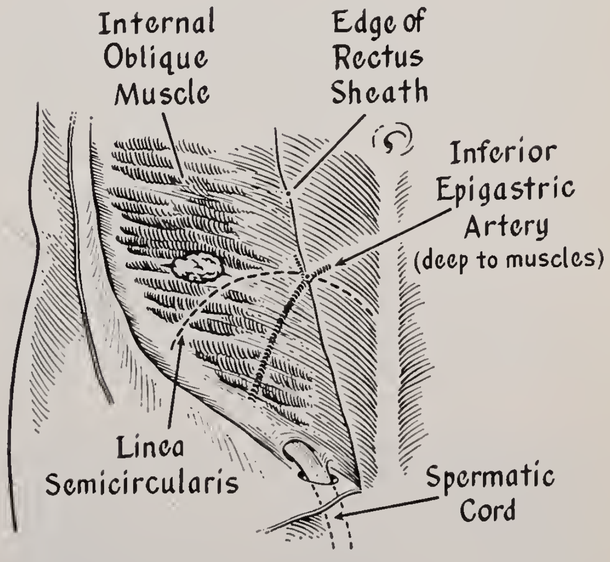

FIGURE 3: An artist's illustration of the course of the inferior epigastric artery deep to the abdominal muscles. The orifice through which the lateral branch of the inferior epigastric artery passes has received great emphasis as the site of the Spigelian hernia. The point where the semilunar line crosses the fold of Douglas has also been incriminated as the site of Spigelian hernias.

surgically corrected at the Minneapolis Veterans Administration Hospital.

Lower abdominal tenderness or pain aggravated by straining or standing and relieved by lying down is characteristic of a Spigelian hernia. The patient may complain of a lump that comes and goes and is located below the umbilicus and lateral to the rectus muscle; it may have a gurgling sound. A Spigelian hernia may stimulate appendicitis, cholecystitis, urinary bladder stones, salpingitis, appendiceal abscess and hematoma or tumor of the abdominal wall. When the ordinary abdominal exploration does not explain lower quadrant pain, the anterior abdominal wall should be carefully palpated from the peritoneal side for the defect of the Spigelian hernia as the hernia may well reduce under muscular relaxation or the slightest manipulation at the time of surgery. Herniations through the semilunaris are usually small and spread beneath the intact external aponeurosis, but large Spigelian hernias do occur.[9]

A symptomatic hernia should be surgically repaired. The neck of the sac should be ligated or sutured after it has been dissected free. As with any hernia, nonviable intestine or strangulated omentum should not be overlooked. The peritoneum and transversalis fascia are sutured and the overlying muscles and aponeurosis are closed with interrupted sutures. A Mayo type repair is sometimes used.[5] A transverse incision over the point of tenderness is very useful.

SUMMARY

A case report of Spigelian hernia with a Richter's component has been presented with a brief review of the literature. In cases of lower lateral abdominal pain and/or tenderness, the differential diagnosis includes Spigelian hernia. Identification of the hernial orifice with ligation or suture of the sac and repair of the overlying muscles and aponeurosis constitutes adequate surgical therapy.

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Team physicians, coaches, and trainers jammed the Rackham Building conference room to participate in the MSMS Conference.

Team physicians and coaches from Ottawa County talk with James Feurig, M.D., lower left, chairman of the MSMS sponsoring committee and MSU team physician, during the annual Sports and Medicine Conference. Each year, the Ottawa County Medical Society sends a group to the conference as a public relations project.

Coaches, Trainers Team Physicians Get Many Pointers

One hundred coaches, trainers, principals and team physicians conferred in Detroit for the Third Annual Michigan Conference on Medical Aspects of High School Sports, sponsored by MSMS and the University Center for Adult Education (WSU-EMU-UM).

Richard H. Smith, M.D., right, of Detroit, chats with an old friend, Leslie M. Bodnar, M.D., Notre Dame team physician, during the recent MSMS Conference. Doctor Bodner, who spoke on "Ankle and Knee Injuries," was an instructor in South Bend, when Doctor Smith was interning there.

Robert J. Murphy, M.D., team physician at Ohio State University, makes a point on "Medical Aspects of Athletic Conditioning" to an audience of team physicians, coaches, and trainers at the MSMS Conference at the Rackham Building.

Reviewing some of the comments made by Howard (Jeep) Mehaffey, D.D.S., right, a former U-M fullback and guard — now with the Michigan Department of Public Health — are William Taft, center, Lansing Waverly High coach, and H. Ross Hume, Jr., M.D., of Detroit, a member of the MSMS sponsoring committee and physician for the Detroit professional soccer team.

CITES STATISTICAL DIFFERENCES

Says Programs for Aging Need More Sophisticated Approach

The concept that people over 65 are essentially alike is one of America's "romantic fallacies." Vast differences exist in income, age, sex and education, according to Dean Walter M. Beattie, Jr., Syracuse University School of Social Work.

Dean Beattie, who spoke at a Wayne State University Symposium, "Extending the Life Span: The Impact on Man," noted that within each five year period more than a third of the older population is new to the age group. All of these newcomers have lived through a different period of history, a somewhat different culture, changed schooling, changed economic conditions than have older members.

These differences should be taken into account when planning services, housing, options and alternatives. Yet, most of our planning and service provisions have been based on the concept that somehow all people over 65 are alike, he said.

A statistical breakdown of group characteristics shows the need for a more sophisticated approach when developing programs for our older population, he intimated.

EACH YEAR SOME 1.4 million people reach 65 years while 1.1 million die. Thus, some 300,000 older persons are added annually to the older population. This group exhibits vast differentials of experience, resources, and background than those 73 years and older, born before 1894, who make up half of the older population. Of every 100 older persons today, six are 85 and older. This six percent represents about one million people born before 1883 and includes some 16,000 Centenarians born before or during the Civil War.

The older population exhibits a disproportion of sex ratios: currently 11 million women to about eight million men. In the younger aged groups, 65-74, there are 125 women for every 100 men. At the other end of the continuum, 85 and over, there are 160 women for every 100 men.

Dean Beattie related to the WSU symposium the differences in education to earnings, work and social status, communications, understanding, taste, pursuits and attitudes. Currently, nearly 17 percent, three million of the older population, have less than five years of elementary schooling. They are functionally illiterate. Five percent are college graduates. But a different group of older persons will emerge by the end of the century, he said, in terms of educational resources and ability to cope with changing situations.

CONTRARY TO POPULAR belief, only a small minority of the aged live in institutions. Ninety-six percent live in the community, about 70 percent in family settings and 26 percent alone or with relatives. Close to 30 percent of those 65 and over, who reside outside of institutions, are at or below the poverty level.

Their biggest source of income, almost one-third of total revenue to all over 65, is earnings. The combination of payments from regular retirement programs contribute about 40 percent; 30 percent is derived from Social Security and six percent from Railroad Retirement and Civil Service. Only three percent of income is attributed to private pension plans.

THE OLDER POPULATION spends almost all disposable income on a hand-to-mouth basis for consumption goods: food, shelter, clothing and medical care. They represent very large proportions of urban poor.

Dean Beattie told the Detroit audience that the median value of all assets of older people totals some $11,200. But if one takes away home ownership, the median assets total only $3,000. Personal debt amounts to about one percent of assets.

He suggests that sound social policies, which would vest the right to retirement benefits in the individual and allow people to "carry" retirement provisions from one area of employment to another, could substantially raise the economic level of future retirees.

"In consumer patterns, older persons live a very marginal life as compared to the rest of the population," he concluded.

(Statistical data for Beattie's comments were taken from: "A Profile of the Older American," by Herman B. Brotman, U.S. Department of Health, Education and Welfare, Oct. 16, 1967).

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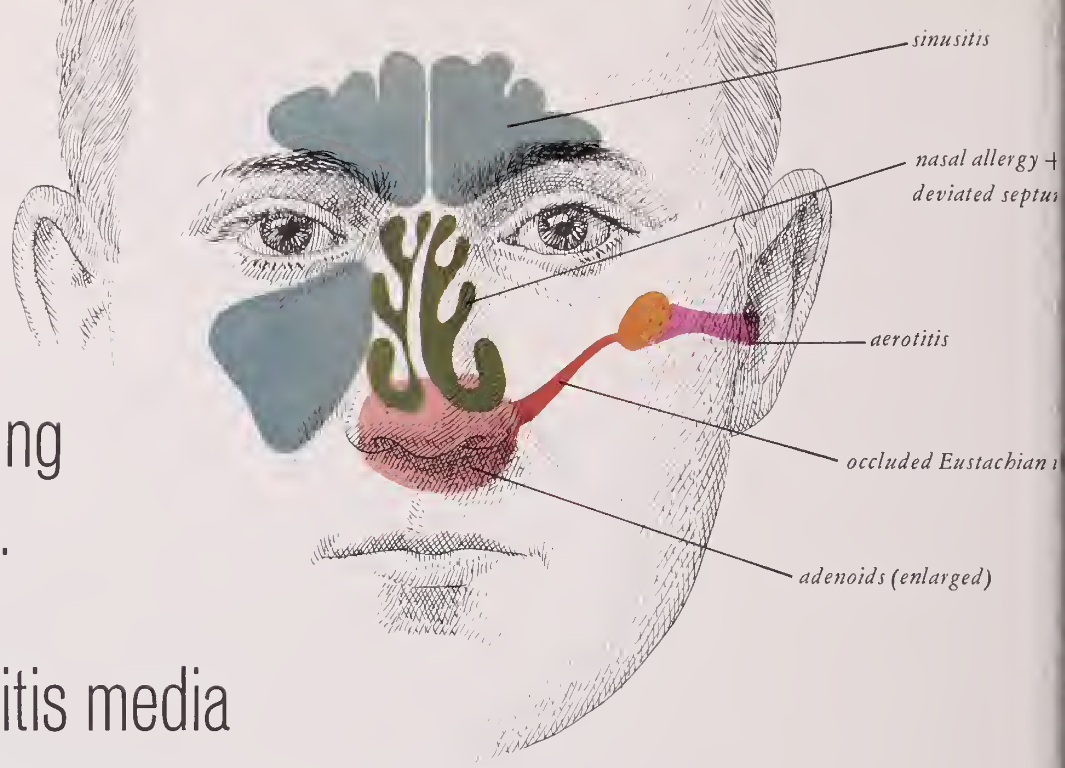
this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

the first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

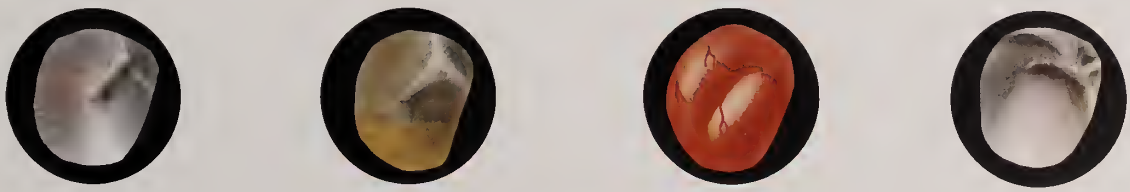
If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal *Acute Serous* *Acute Purulent* *Chronic Serous* dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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You can relieve his congestion and sniffles and her concern with

“The Orange Medicine”

You know it as Triaminic Syrup, but mothers of kids with colds and allergies know it as the orange-colored, good-tasting medicine that makes life a lot more livable at either end of the teaspoon. Triaminic Syrup contains not one, but two antihistamines, plus an effective oral nasal decongestant. This balanced formulation has promptly and effectively relieved nasal congestion for so many.

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Each teaspoonful (5 ml.) contains: phenylpropanolamine hydrochloride 12.5 mg.; pheniramine maleate 6.25 mg.; pyrilamine maleate 6.25 mg. Side effects: Drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis. Dosage: Children 1-6, ½ tsp.; Children 6-12, 1 tsp.; Adults, 2 tsp. Administer every 4 hours. Supplied: Bottles of 4 fl. oz., pints.

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Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

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1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

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A different salicylate structure—
with no coating, no buffering
and it is sodium free

magan
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Salicylate, W-T

microphotograph of magnesium salicylate crystals

Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

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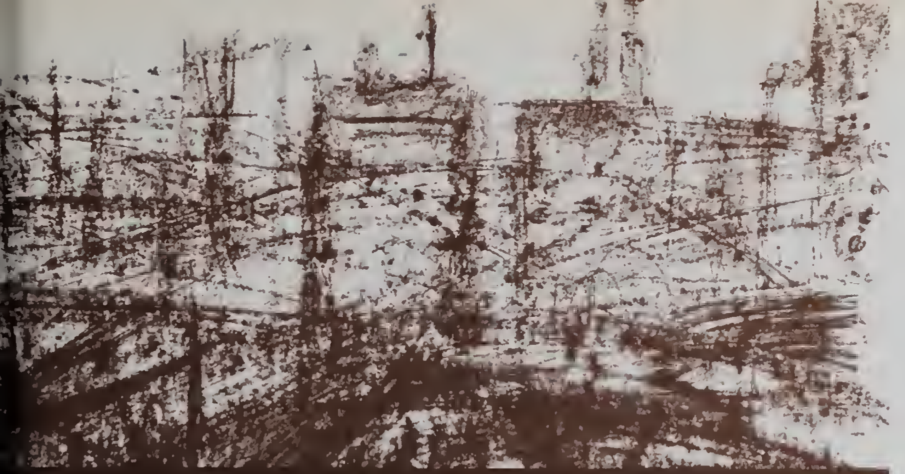

Urge Every MSMS Member Attend September 25-26

Ask Residents, Interns, Seniors Confer Sept. 26

An educational "Conference on Office Management" will be offered for residents, interns and senior medical students on the afternoon of September 26 at the Sheraton-Cadillac Hotel in Detroit, during the MSMS Annual Session.

The MSMS Liaison Committee with Residents, Interns and Senior Medical Students has studied various topics for the conference. The Committee decided that the program should focus on basic principles of office management. Conference topics were narrowed to four: (a) opening an office, (b) selecting personnel, (c) billing system, and (d) evaluating partnership prospects.

"The Committee is grateful to Merck, Sharp and Dohme for financial support of this conference and feels that this unique event will not only be of educational benefit to the young or prospective physician but also will serve as an effective way of introducing him to the activities of the Michigan State Medical Society," reports Norman D. Henderson, M.D., East Lansing, chairman of the sponsoring MSMS Committee.

Four Day-Long Courses Set for Annual Session

The two-day annual MSMS Annual Scientific Session, Wednesday and Thursday, September 25-26, at the Sheraton-Cadillac Hotel in Detroit, will feature four, day-long postgraduate courses in "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases," and "Difficult Decision in Digestive Diseases."

The Wednesday, September 25, courses on "Infectious Diseases" and "Pulmonary Diseases" will run simultaneously from 9:00 AM to 5:00 PM. Each course will involve approximately six hours of in depth discussion and presentation.

"Blood Diseases" and "Difficult Decisions in Digestive Diseases" will be held on Thursday, September 26 also from 9:00 AM to 5:00 PM.

All courses are limited to 45 persons; cost is $10 per course.

Advance registration is essential because of limitation of space.

Michigan Medicine will print further course information as it becomes available.

MARK CALENDAR TODAY FOR ANNUAL SESSION

New Applicants Deadline Soon For MVF-2 Plan

A new and expanded program of Blue Cross and Blue Shield benefits is now available to eligible MSMS members . . . but July 10 is the deadline for new applicants.

The new program inaugurates a realistic and up-to-date program of hospital and physician care benefits for MSMS members and their families. In addition to the well-known basic Blue Cross and Blue Shield benefits, it introduces benefits for care in convalescent facilities — outpatient psychiatric care — expanded benefits for nervous and mental conditions — plus the new Michigan Variable Fee system for paying physicians' reasonable and customary charges (MVF-2).

Complete details, rates and an application were mailed recently to every member.

Coverage will begin August 1.

All physicians presently enrolled in the MSMS-group for Blue Cross and Blue Shield coverage have also received details about the new MVF-2 Plan and will automatically be transferred.

International Health Speech Available

MSMS members interested in obtaining a copy of the address by William S. McNary, Michigan Blue Cross president, advocating an international reciprocity program for health care protection may obtain a copy by writing to Michigan Blue Cross, 441 E. Jefferson Avenue, Detroit 48226. Mr. McNary, speaking at the recent International Conference on Voluntary Health Insurance in Sydney, Australia suggested a voluntary program to answer the health problems of the international traveler.

Duncan J. McColl, M.D., center, Port Huron, who died May 26 received recent honors at the Wayne State University Medical School Alumni Association banquet in Detroit, May 15. Doctor McColl, who was graduated from WSU in 1893, was in the banquet spotlight with James J. Aiuto, M.D., left, the new president of the WSU Medical School Alumni, and Mario A. Petrini, M.D., retiring president.

LOWINGER LEADER IN RIGHTS GROUP

Paul Lowinger, M.D., Associate Professor of Psychiatry at Wayne State University, was elected national vice chairman of the Medical Committee for Human Rights at the annual convention in Philadelphia.

RECEIVES ADA AWARD

The American Dermatological Association has awarded its first Carl Herzog Fellowship for training teachers and researchers in dermatology to John J. Voorhees, M.D., Ann Arbor, a second-year resident in the U-M Hospital department of dermatology. The award includes a stipend of $10,000, and also $2,500 for equipment and travel.

D. J. McColl, 99, Dies; Was Honored By MSMS, WSU

Michigan's Foremost Family Physician for 1954, Duncan J. McColl, M.D., died May 26 in Port Huron Hospital at the age of 99.

"Doctor McColl has always devoted his energy and attention first to his patients and lastly to himself," said Charles N. Hoyt, M.D., acting secretary of the St. Clair County Medical Society, when Doctor McColl was named by MSMS as the Foremost Family Physician.

Illustrating this quality of Port Huron's late beloved physician, Doctor Hoyt cited an instance in 1952 when Doctor McColl, himself in the hospital with hemoglobin of 6.5 grams, could not be found by his physician: "In about an hour he returned to his room — he had been in the delivery room attending one of his patients."

On May 15 this year, Doctor McColl had attended the Wayne State University School of Medicine Alumni Association banquet, and had been presented with a Centennial Award.

Born on Nov. 24, 1868, on a farm in Elgin County, Ontario, Doctor McColl in 1889 entered the Detroit College of Medicine, which evolved into the Wayne State University School of Medicine.

He was graduated in 1893 and had been WSU's oldest living alumnus.

In 1896, Doctor McColl married Miss Helen Marr Clark, of Harbor Beach, and they settled in Elkton. Doctor McColl practiced there for 13 years, becoming the first president of the village. Then came six years in Croswell, and two years at St. Joseph Hospital in Milwaukee. In 1914 he moved to Port Huron where he practiced the rest of his life. He delivered more than 8,000 babies in Port Huron.

Survivors include a son, Clarke M. McColl, M.D., Detroit.

THREE U-M DEANSHIP CHANGES ANNOUNCED

John A. Gronvall, M.D., of the University of Mississippi Medical School, has been appointed Associate Dean for the U-M Medical School to succeed Alexander Barry, Ph.D., who will join the University of California School of Human Medicine at Davis. Dr. Gronvall, a pathologist, is associate dean and associate director of the University of Mississippi Medical Center.

Robert A. Green, M.D., who has served as assistant dean part time the past year, was appointed to the new position of Associate Dean for Student Affairs. The new office of Associate Dean for Academic Affairs will be filled by George R. DeMuth, M.D., member of the U-M pediatrics staff since 1956.

AREA REHAB WORKSHOP JUNE 27 AT SAGINAW

A Conference on Rehabilitation and Long Term Care will be held Thursday, June 27 through the joint efforts of the Bay-Arenac-Iosco, Saginaw, and Midland County Medical Societies. The MSMS Committee on Aging and the Saginaw Veterans Hospital also are cooperating in the seven-hour program at Saginaw County Hospital Rehabilitation Center.

MAP TV PROGRAM SWEEPS AWAY BLUES

Several Michigan physicians, Charles W. Sellers, M.D., associate editor of the *Detroit Medical News,* Bruce L. Danto, M.D., Director of Community Psychiatry at the Detroit Psychiatric Institute, and C. Howard Ross, M.D., an Ann Arbor writer, editor, and lecturer, joined host Hugh Brenneman, MSMS Executive Director, in a discussion of "Formula for the Blues" over WJIM-TV, Lansing, in the weekly series sponsored by the Michigan Association of the Professions.

MSMS, State Bar Studies Fee for Expert Medical Witness

What happens to the physician's fee, when on request of an attorney, he makes preparations to give testimony in court and then finds that the case is settled before the actual court appearance?

In 1957, MSMS and the Michigan Bar Association agreed on a statement of principle which read . . . "It is the responsibility of the attorney to advise his client of the physician's assistance and services in the case, and thus to cooperate with the physician for the purpose of seeing that such physician receives a reasonable fee for such services."

A joint meeting of the MSMS Liaison Committee with the State Bar of Michigan and the State Bar Medico-Legal Committee this spring recommended a rewording on this statement of principle as follows: "In cases where the physician aided in preparing the case but did not have the opportunity to testify or failed to testify because of a settlement prior to his being called as witness, it is the responsibility of the attorney to pay to the physician a reasonable fee for services rendered."

MSMS Council, at its April 17 meeting, approved this recommendation for rewording of the statement of principle.

The State Bar is currently studying the recommendation.

SLAGLE, SMITH ON NAT'L COUNCIL

George W. Slagle, M.D., of Battle Creek, chairman of the American Medical Association's Council on Medical Service, and Donald Smith, M.D., public health professor at the University of Michigan, have been named to a 21-member Advisory Council of the National Center for Health Services Research and Development, a new agency of the federal government.

The new center will work with universities, industry, hospitals, practitioners, and research institutions to seek new ways of delivering health care.

Doctors Slagle, a MSMS past president, and Smith will work with the advisory council which will be consulted on program development and practical operational problems involved in Medicaid (Title IX of Social Security).

GENESEE COUNTY PLANS 1969 DIABETES DAY

The Genesee County Medical Society has set the date for its fourth Diabetes Day, October 29, 1969.

Chairman for the Flint meeting next year is Franklin W. Baske, M.D.

John W. Moses, M.D., right, Detroit, arrives June 5 at the MSMS headquarters for his first meeting of the MSMS Publication Committee and the MSMS Council following his election by The Council in May as the new Scientific Editor of MICHIGAN MEDICINE. The official greeter is Brooker L. Masters, M.D., left, Fremont, member of The Council and chairman of the Publication Committee.

D. Bonta Hiscoe, M.D., of Lansing, talks with George Hunt, right, Managing Editor of LIFE Magazine, who gave the annual Yates lecture at Michigan State University recently, and Andrew Hunt, M.D., dean of the College of Human Medicine at MSU, brother of the LIFE Magazine editor.

Explains Dilemma In Medical Writing

"Whenever a story is chosen, there is a dilemma," said George P. Hunt, Managing Editor of *Life* magazine: "Is the story worth doing? Is now the time to do it? In the field of medicine, this dilemma is intensified."

Delivering the annual Yates lecture at Michigan State University, recently, Mr. Hunt observed that "In other stories there are clear rules and definite places where stories are found. But in medicine a major advance can just as easily come out of a small college or from Cal Tech."

"Even the experts," he continued, "don't all agree sometimes on whether something is really the first, the most, or a breakthrough."

"Another aspect of the dilemma," the *Life* editor said, "is that we have to be careful in reporting new advances in medicine. Will the story scare people? Will it raise false hopes?"

Mr. Hunt is the brother of Andrew Hunt, M.D., dean of the College of Human Medicine at MSU. The Yates lecture is an annual event sponsored by MSMS and other organizations which are interested in the advancement of science writing.

AMA Lauds MSMS Projects

Three projects of MSMS are described in the current issue of the *AMA PR Doctor* magazine published for county and state society doctors and staff members interested in better public relations.

One article suggested ways to improve town-gown relations and praised the "handsomely-designed" MSMS *Michigan Medicine* issue in 1967 which saluted the U-M Sesquicentennial.

Another voiced concern for better smoking-health educational programs and described MSMS support of the Michigan Council on Smoking and Health.

The third article reviewed the 1967 MSMS Workshop on Medical News Reporting sponsored at the U-M for science reporters, editors, program directors of TV and radio stations, as well as doctors serving on PR committees and bulletin editors.

Mutual Dependency

(The following editorial appeared recently in the Port Huron Times Herald:)

The Michigan State Medical Society is considering new approaches in education and enforcement to buck the spread of health quackery.

It's a big order, and an urgent one.

Dr. J. J. Lightbody, Medical Society president elect, says that phoney cures cost Americans some $3 billion a year. More than that, he says, they take more lives annually than all crimes of violence combined.

> **"Fraud, theft, death are strong, ugly words, but no single three words so well sum up the price society pays for lack of an effective program," he said.**

The *Medical World News* in its March 29 issue examines facts and figures in one phase of quackery, treatments that are supposed to "cure" arthritis. Medical science admits that it has no cure at the present time, but 13 million victims of this ailment are receptive to almost anything that will give them a hope of relief, even a fantastic one.

It is estimated that at least 90 per cent of arthritis patients at one time or another fall prey to the empty promise — and frequently dangerous treatment — of an unqualified practitioner.

* * *

The problem is compounded because many of the quacks operate under a facade of respectability. Victims of their trickery are reluctant to bring action against them because they don't want to admit they have been cheated. Investigators term documented cases "the top of an iceberg," with no one knowing how much goes on under cover of anonymity.

The medical profession takes on a difficult assignment in seeking answers to this problem. It must do so in a way that will not discredit legitimate practitioners of the healing arts.

And it must do so in the clear understanding that it has a vested interest in closing down phoney health mills. The patients the investigators save may be their own.

Yet the hard fact is that there is no other source of expertise by which to judge the legitimacy of medical treatment than those who are of the medical profession.

> **The people must depend on them for honest judgment in this regard just as their patients depend on them for honest and competent judgment about physical disorders.**

We can only urge the medical society to press forthrightly for means to control the quacks, wherever they are to be found, under whatever guise they are operating. And we urge every concerned citizen, and every organization, to co-operate in the effort.

The shattered hopes of hapless victims, along with uncounted wasted dollars and untimely deaths, are realities that must not be ignored. ☐

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WE WANT YOU TO BE SURE TO GET
THE NEXT ISSUE OF THE
MICHIGAN MEDICINE

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
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5 mg

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

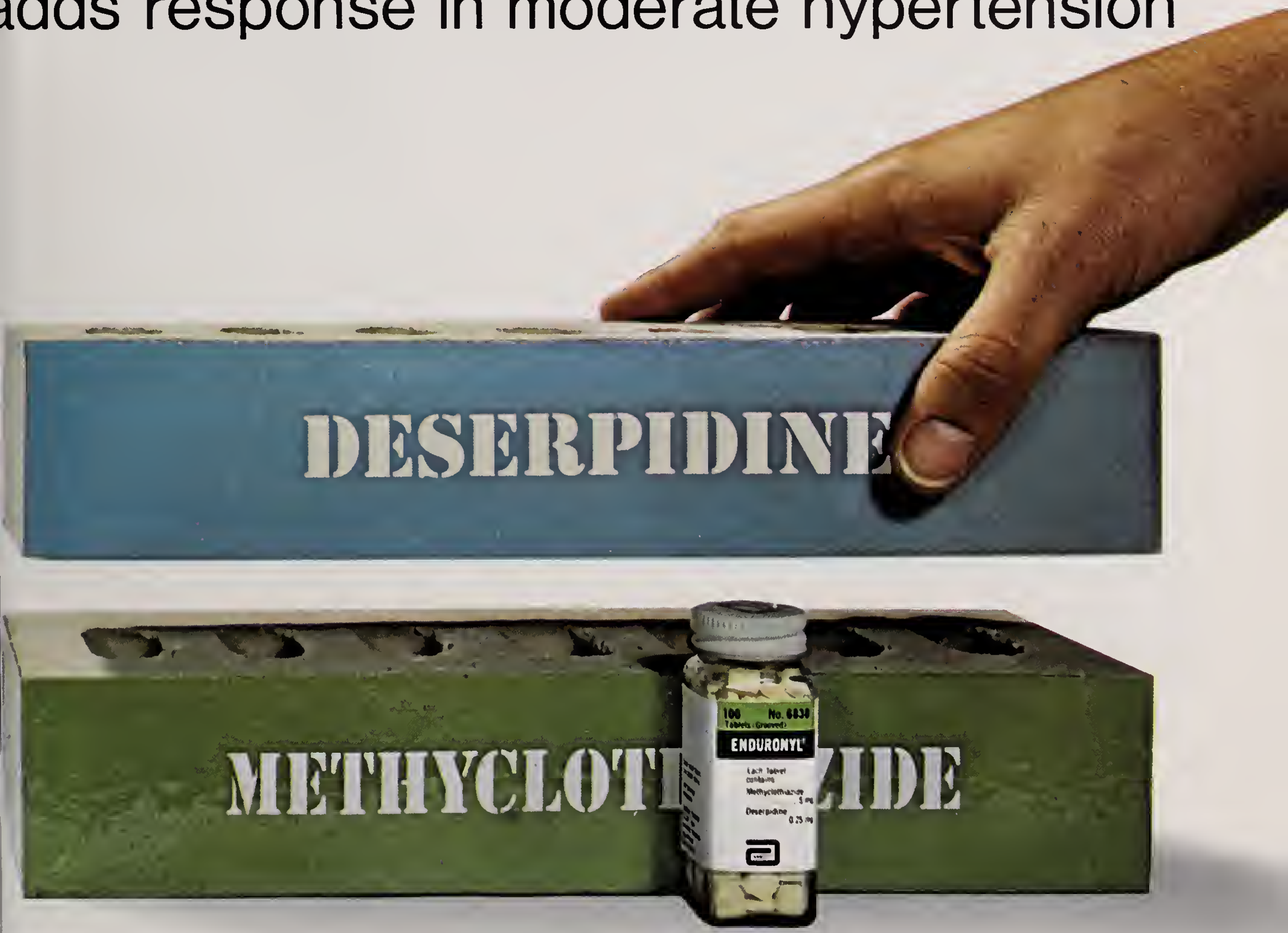
Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day
ENDURON
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension


DESERPIDINE
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Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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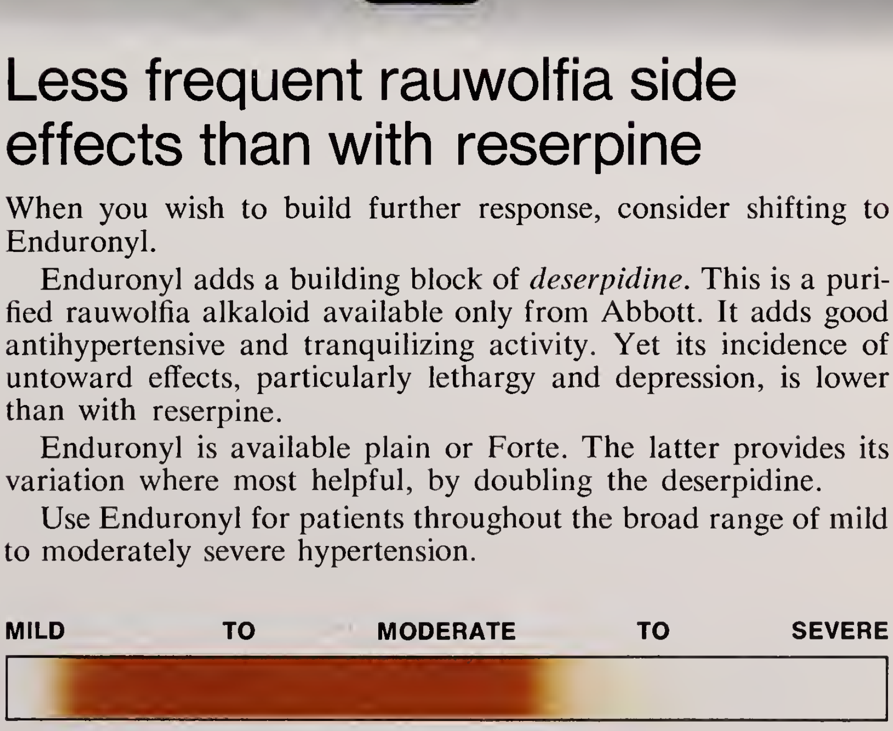
THYCLOTHIAZIDE 5 mg. with
ERPIDINE 0.25 mg. or (FORTE) 0.5 mg.


MILD
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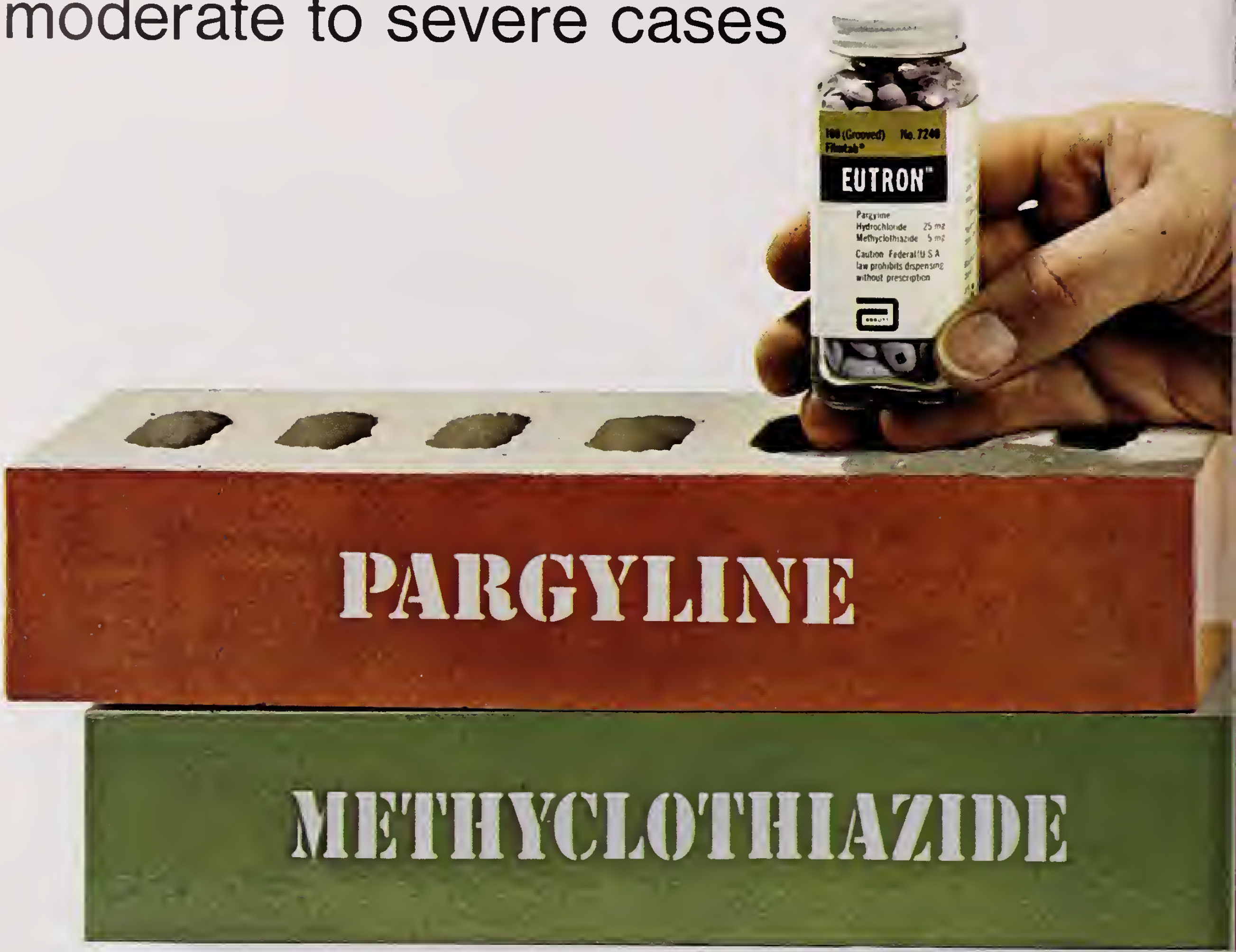
Eutron: A unique combination for handling moderate to severe cases



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Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

8010

ENDURON®
METHYCLOTHIAZIDE

ENDURONYL®
Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™
Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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COMING EVENTS

COLLER-PENBERTHY-THIRLBY EVENT SET AT TRAVERSE JULY 25-26

All Michigan physicians are invited to participate in the 48th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 25-26.

The excellent program will begin at 9:00 a.m., July 25 and conclude at noon, July 26, according to James W. Hall, M.D., local chairman of the committee on arrangements. He reports that the out-of-state medical educators will come from California, Ohio, Florida, Missouri, Maryland, Nebraska, Minnesota, Texas, and Illinois.

MICHIGAN MEDISCENE

July 18-20 — MSMS Midsummer Session of The Council, Grand Hotel, Mackinac Island

July 20-21 — MSMAS Summer Seminar, Boyne Highlands, Harbor Springs

July 25-26 — 48th Annual Coller-Penberthy-Thirlby Medical Conference, Park Place, Traverse City

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — Woman's Auxiliary to the MSMS, Annual Convention, Statler-Hilton Hotel, Detroit

Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

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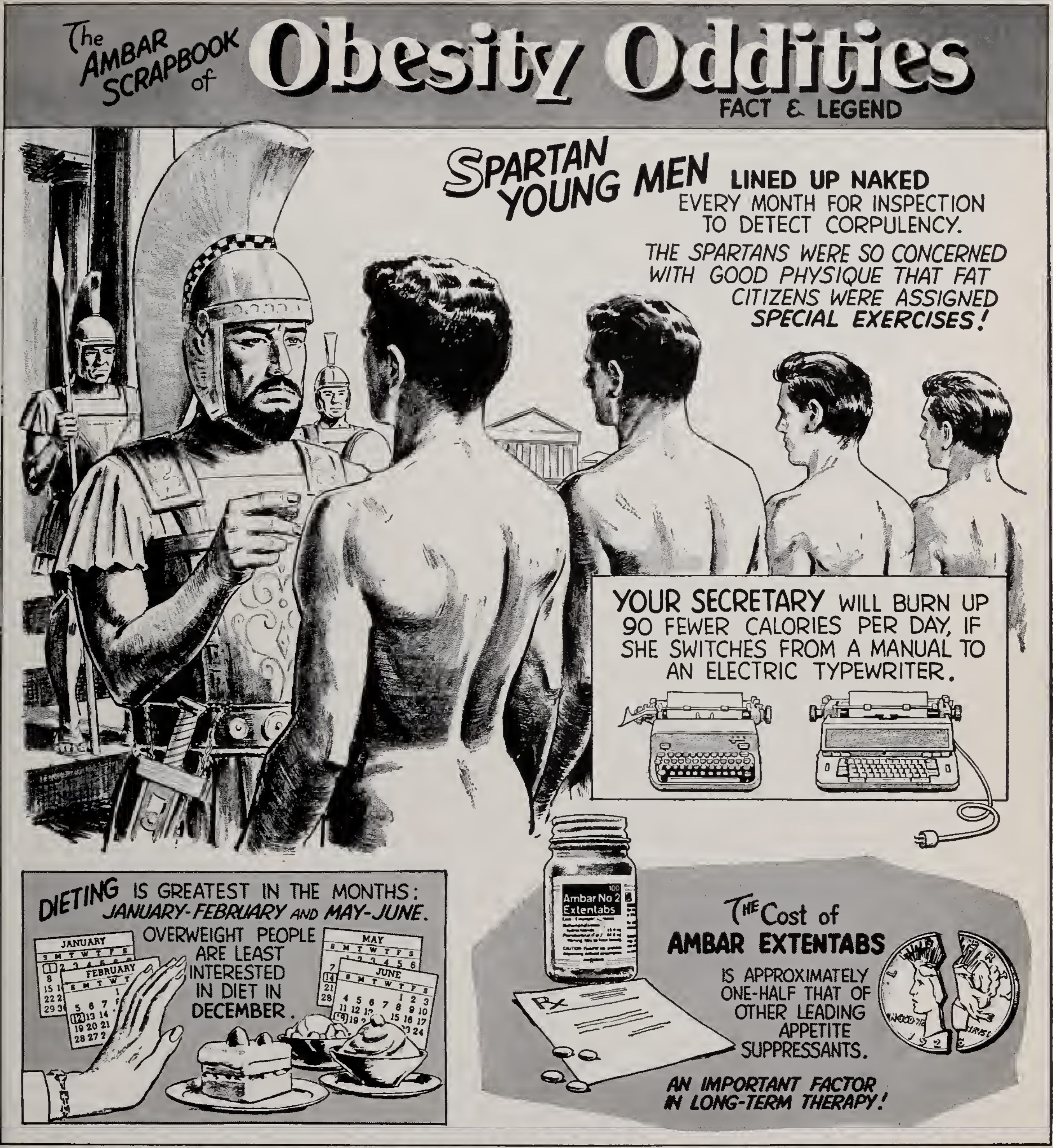

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Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Only 4.4% of patients taking Oracon discontinued it because of side effects

Oracon in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

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Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing Oracon

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of Oracon in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with Oracon. Therefore, if such tests are abnormal in a patient taking Oracon, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. Oracon should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Oracon therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Oracon therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, Oracon should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Oracon may mask the onset of the climacteric. The pathologist should be advised of Oracon therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

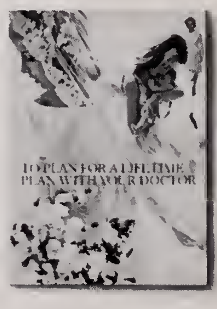
continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control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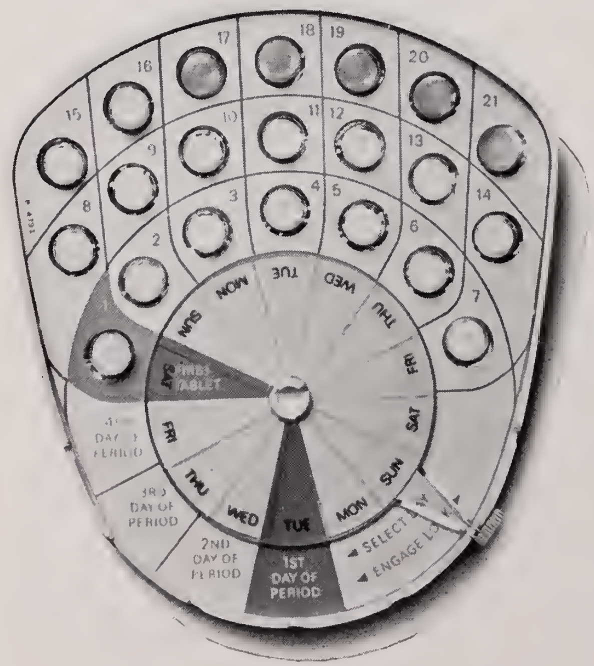

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Advice Offered at WSU Clinic Day To Help Doctor as Marriage Counselor

BY PETER HOHEISEL
OF THE MSMS STAFF

What can the physician do, and how does he measure up, as a sex and marriage counselor?

What are the special problems in a physician's marriage?

Those were the central questions which the annual Wayne State University School of Medicine alumni program examined recently.

A total of 560 persons, the largest crowd ever, gathered in Detroit May 15 to hear five papers and a panel discussion devoted to "Human Sexuality and Modern Marriage."

SEVERAL SPEAKERS STRESSED that one of the reasons physician's have difficulty with their own sexuality, and in being effective counsellors to their patients, is that sex education in medical school is generally confined to reproductive physiology and sexual anatomy with the result that physicians are not significantly better equipped in terms of sexual attitudes and information than is any comparably educated person.

"Many recent surveys show," Peter A. Martin, M.D., Detroit, said, "that doctors are having trouble with sexual problems — their patients as well as their own. Physicians are improperly trained in medical schools to handle such problems and have trouble getting themselves and their patients to discuss sexual difficulties. It is unlikely that the doctor would be able to go further towards solving his patient's sexual problems than he is able to go with his own."

New president of the WSU Medical Alumni Association James J. Aiuto, M.D., backs this view: "There hasn't been sufficient training at the medical school level. At present only the University of Pennsylvania and Bowman Gray School of Medicine have integrated sex and marriage counselling into their curriculum. These schools also have good postgraduate programs for physicians in this field. Lafayette Clinic, however, is taking some steps in this direction by offering to interested physicians lecture series on this topic."

OUTLINING HOW THE physician can increase his effectiveness as a marriage counsellor was Richard H. Klemer, Ph.D., clinical professor of psychiatry at Bowman Gray School of Medicine. He cited seven steps which the physician can take to help his patient resolve a marital difficulty:

MARTIN

KLEMER

1. Creating the climate in which the patient can talk about his problems.
2. Providing for the ventilation of emotional catharsis.
3. Providing the reassurance of acceptance of the patient's attitude and perhaps an additional reassurance as well.
4. Diagnosing the real problem with the patient.
5. Encouraging the patient's education and evaluation.
6. Helping the patient to examine all the possible alternatives, and to decide upon a specific action.
7. Motivating the patient toward completing the chosen action.

DOCTOR KLEMER WENT on to discuss three of these steps: Creating the climate, acceptance and reassurance, and motivation.

According to Doctor Klemer, three basic ingredients to creating the climate are:

1. The security given by the confidential attitudes and the physical surroundings in which the counseling takes place.
2. The interest and concern exhibited by the counselor.
3. The non-judgmental attitude of acceptance with which the patient's statements are received by the counselor.

"The non-judgmental attitude of acceptance is especially important," Doctor Klemer said. "This can be achieved only when the counselor has self-understanding of his biases and an ability to tolerate ideas and behavior which conflict with those biases."

"This kind of self-knowledge involves a lot of rigorous self-analysis and often some evaluative help from another professional person," he continued. "Only the physician who is honest with himself can hope to project the necessary attitude of non-emotional objective interest which will ultimately help the patient."

"Another major function of the physician counselor," Doctor Klemer said, "is to provide supportive acceptance and reassurance to the patient. In practical marriage counseling, as in psychotherapy, at least some of the necessary reassurance comes from the quiet acceptance of the patient's attitudes and verbalizations by the counselor. That the counselor is willing to hear such hostile and guilt-ridden thoughts and not pass judgment is often enough for the patient."

"THE FINAL MAJOR FUNCTION of the physician-counselor is to motivate his patient," Doctor Klemer concluded, "to follow through with whatever course of action has been decided upon by the patient after an examination of all the alternatives. This is the point at which the use of some actual direction and persuasion by the counselor not only seems to me to be justified but is also probably inevitable. Very often it is the physician's willingness to reinforce the patient's decision which provides the impetus for the patient to carry his plans through to a successful conclusion."

"Naturally this requires a considerable self-confidence on the part of the counselor himself. An important part of the counselor's ability to help his patient comes from the strength of his conviction of his own ability to help and his willingness to transmit that hopeful belief to that patient. In the end, it is the counselor's personality, his warm self-confidence, which will provide the acceptance, the reassurance, the cooperation and the motivation to help his patient solve his marriage problem."

WHILE IT IS TRUE that, as Harold Lief, M.D., director of the Division of Family Study at the University of Pennsylvania School of Medicine, pointed out, "not necessarily every physician, just as not every teacher, can do a good job in sex education," nevertheless the physician, because of the trust and confidence which the patient places in him, is in a unique position to counsel his patient with sex and marital problems.

THAT THERE ARE special problems in a physician's marriage was attested to in comments by Doctor Martin, clinical professor of psychiatry at both U of M and WSU schools of medicine, when he noted that "Doctor's wives constitute an unusually high percentage of the total number of professional men's wives admitted to the Institute of Living in Hartford, Connecticut."

"There is one marriage pattern which I have seen repeatedly in doctor's marriages," continued Doctor Martin. "The husband is a good, kind, hard-working humanitarian devoted to his mistress-medicine. Everyone thinks how lucky his wife is to be married to such a paragon of virtue. This unassailable position drives his wife to distraction. She over-reacts. She can't attack her husband's good deeds. If only he had a mistress instead of medicine, he could be the bad one and she could be the good one."

"In this pattern, the husband's game is, 'Look how good I am. I am so good and patient to accept such a horribly unappreciative, sick wife. She is bad and unlovable.' The wife's problem is that she doesn't know how to beat this game. She refuses to see him as he is because she is afraid to lose him. She fantasies that he is great and wonderful. She expects him to love her. If he doesn't, she feels she is guilty and unlovable. Her mistake is that she wants him to love her no matter how badly she reacts, no matter how sick she gets. He is so in love with being a long suffering, unappreciated hero he can't afford to break this picture by building her self esteem, recognizing her good points, her contributions, her desire for love and her attractiveness as a sexual object."

After discussing the changing attitudes toward sex in our society, especially the increasing demand for sexual fulfillment on the part of women, Doctor Martin observed that the life of a doctor today "has resulted in difficulty in sharing in the life of his family." He listed several stress points. They were:

One, the doctor is an authority. Perhaps, in part he chose his profession because he likes a position of authority and all sorts of attitudes both rational and irrational are developed towards him.

Two, the doctor is a public figure, is in the limelight, which his family shares in a somewhat different way: while he is subject to adulation as well as criticism, his wife may get a little reflected glory, but is more likely to have her weaknesses or mistakes greatly magnified.

Three, the doctor frequently has a legitimate excuse for being away from home much of the time and for being undependable for social engagements and family occasions.

Four, the doctor has an opportunity for contacts with nurses, patients, secretaries and his wife may well exaggerate his opportunities and explanation of them, because of anxieties relating to her own self-assurance and sense of desirability as a woman. □

Goins Reports on Detroit Mother-Child Care Program

About 3500 indigent Detroit mothers have an opportunity for free prenatal, delivery, and post delivery care for themselves and care of their infants up to one year of age through the Detroit Maternity and Infant Care Project.

Currently the DMIC is running clinics in 5 Detroit hospitals which, except one, are near high indigent population areas—Crittenton General, Detroit Memorial, Hutzel, Mount Carmel, and Children's Hospital.

William Goins, M.D., project director, says, "We want to see what can be done to deliver not just maternity but comprehensive care to people whose needs are the greatest."

Not only is the DMIC woman assisted in delivering her baby, but she will also be given instruction on how, when, and what to feed it, as well as how to plan her budget so that she can feed it.

Aim of the project is to treat the indigent mother as a person: To help her use the potentials of her environment in a way which will be healthful to herself and her children.

The DMIC requires no means test for eligibility. "We accept the word of the mother," says Doctor Goins. "Very few people have abused this because if people have the money they generally prefer to go to their own private practice physician.

"Although we have not really made an impact on the high perinatal mortality rate among the poor," Doctor Goins said, "We do feel we are accomplishing our purpose because 90% of the women we help through delivery bring their children back for post delivery care. When the women know they are going to be treated with respect, given adequate time and attention and highly competent medical care, they respond by coming back. The clean wholesome atmosphere where people are kind to them brings the mothers flocking in."

"Compared to city wide statistics among indigent women, we have a very low maternal death rate," Doctor Goins said. "We're getting them in earlier, more often, and we're not losing mothers."

Started in 1964, the DMIC is one of 53 similar projects around the country. Personnel who work at the clinics in the hospitals participating in the project are paid through the project funds. It is funded at about $1 million a year by the Children's Bureau of HEW on a matching basis with the Detroit Health Department. ☐

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Where Does MSMS Stand re Legislation, Forensic Medicine, Laws, Regulations?

Where does MSMS stand on matters of governmental medicine?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS.

The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Various chapters of the book are being printed each month for all MSMS members to study. This month, Chapter Ten is printed in full.

Discussion

Medicare Medicaid

Governmental medicine has descended upon the physician and has become the focal point of concern. Since the beginning of Medicare in July 1966 and the partial implementation of the State Medical Assistance Program (Medicaid) in the fall of 1966, many problems of major and minor importance have developed for the practicing physician.

Medicare Administrative Burden

Initially, the physicians in Michigan discovered that there was a lack of understanding by the patient about the new laws. Doctors became well versed with the provisions of Medicare and made special purchases of hand books in order to understand and explain the many provisions. While it does now appear that the number of complaints is diminishing, Medicare is still an administrative burden for physicians, hospitals, and clinics in a number of areas.

MSMS Participation in Deliberations on Medicare-Medicaid

MSMS has taken a most active role in meeting many of these problems. Michigan doctors have participated in deliberations of governmental agencies (local, state, and national), voluntary medical insurance companies, hospital organizations, public health and social welfare agencies, and in the State Legislature. This, however, is not to say that problems with Medicare-Medicaid have dissipated. A continuous awareness and concern at all levels is necessary.

Generic Drugs

Food and Drug Administration

In other areas the governmental interest in medical practice has placed present methods in question — e.g., the physician's right to prescribe medicines and drugs in accordance with his best judgment. Some federal legislation and some regulations proposed by the FDA seem on a collision course with the practicing physician by proposing to insist that physicians prescribe by generic name rather than brand names as they have been doing of late.

Comprehensive Health Planning Heart-Cancer-Stroke

Other governmental programs (PL 89-749, the Comprehensive Health Planning and Public Health Services Amendments of 1966, and PL 89-239, Heart Disease, Cancer, and Stroke Amendments) are receiving much attention and active participation.

Partnership for Health

Briefly, PL 89-749 authorizes funds to states to provide for developing comprehensive statewide, regional, metropolitan and other local area plans for the *coordination of existing and planned health services, including the facilities and persons required for the provision of such services.* HR 6418 is now before the Congress as Partnership for Health Amendments of 1967. It would amend the Public Health Service Act and extend the authorizations for grants in order to broaden and improve authorizations for research and demonstrations relating to the delivery of health services; improve the performance of clinical laboratories; authorize cooperative activities between the Public Health Service hospitals and community facilities.

Health Czar

In actuality, this legislation could be used to set up a potential health czar in Michigan. MSMS has felt that the "czar," if any, should be the Governor himself, particularly if the plans developed included *all* health services, i. e., mental, medical education, aging, etc., etc.

Heart Disease-Cancer-Stroke Amendments

PL 89-239, the Heart Disease, Cancer, and Stroke Amendments of 1967, is designed to encourage and assist in the establishment of regional cooperative arrangements among medical schools and hospitals for research and training and for related demonstrations of patient care in these fields. It is also intended to afford to the medical profession and medical institutions through cooperative arrangements the opportunity to make available to their patients the latest advances and the diagnosis and treatment of these diseases and to improve generally the health manpower and facilities available.

MARMP

MSMS is fortunate in having as vice president of the Michigan Association for Regional Medical Programs, Inc. (MARMP) an active and dedicated physician, Don Marshall, MD, of Kalamazoo.

Federal Grants

Recently, announcement was made of the receipt of the first federal grant of over one million dollars under this program in Michigan, and other applications have been submitted and are awaiting approval from Washington.

Director of Mental Health

Mental Health Budget

Michigan now has a new director of the Department of Mental Health. Mental health in Michigan was one of the programs that had been affected during the period of the inability of the state to settle the problem of fiscal reform. At this date, it is too early to state that the Department will receive its full budgetary needs and requirements, and receipt of tax revenues will largely determine the scope and extent of this Department's activities for the coming year.

Community Mental Health Centers

President Johnson recently signed into law PL 90-31, the Mental Health Amendments of 1967. This law extends for three years the program of matching grants for the construction of community mental health centers and extends for two years the program of matching grants for assisting and defraying the costs of initial staffing. Another item in this act was an amendment of state plans providing that minimum state standards for these community centers must be in effect by July 1, 1969.

Departments of Public Health, Mental Health, Social Services

These items noted above are, presently, the more prominent of the government health programs. They are not by any means the major ones. The Department of Mental Health is largest in terms of money spent, facilities and personnel employed; the Department of Public Health is of greatest importance to the practicing physician because it is closest to him, "touching" him in the hospital, through the county health department, via surveys and statistics, with laboratory services, etc.

The Department of Social Services, with administrative responsibilities in Medicaid and Medicare, as well as through public-owned hospitals, has become a major factor in medical care. The interest of the State Department of Education in rehabilitation relates its work to medicine.

Military Medicine

Military medicine is important and becoming more so. Not only are many military installations located in Michigan, but the Veteran's Administration has major facilities here, and relationships with the military for the care of families of servicemen is a big program growing bigger.

Administrative Code

Final planning on machinery to add a new dimension of program (and service) to MSMS governmental activity by anticipating and helping to mold the rules and regulations of state agencies which will, when published as the Administrative Code, parallel the laws of the state, is under way.

A new subgroup of the Legal Affairs Committee will function within MSMS in a fashion similar to the Joint Legislative Committee on Administrative Rules. An MSMS staff man will have specific responsibility to regularly contact health-related agencies and seek out plans for development of rules and regulations; he will inform the Legal Affairs subgroup of these plans and assist the Society in effectively bringing medicine's thinking to the agencies involved.

When necessary, MSMS will make appearances before the Joint Legislative Committee itself. This activity will require extremely close liaison with the Attorney General Department, the Secretary of State Department, and the Legislative Service Bureau as well as with the several agencies and the Joint Legislative Committee.

We also plan to sharpen our reporting activity with regard to new health laws adopted (or new administrative rules and regulations) by articles in MICHIGAN MEDICINE of an analytical nature — e. g., what do the new laws actually provide? What effect will they have on (1) individual practice, (2) overall quality health care?

Government Importance

The significance of all of the above is simply this: *Government has become the largest and strongest single force in medicine in Michigan.* This is overwhelmingly so if medical education is considered part of "government."

Freedom to Practice Medicine

But to blindly thrash against the bonds that government appears to be fashioning for the profession is not the answer. Quite the contrary, it has the effect of making the bonds stronger and tighter. The only way to maintain the freedom

"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."

—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

and dignity of medicine is to be better informed, more alert, and more *unified* than medicine's would-be captors. It should be kept in mind that "government" is not a single unit but is many diverse units, each with separate jealousies, budgets, loyalties, responsibilities, etc. If the medical profession with its clear representation of the major purveyors of health remains unified, flexible, and active, it can call enough decisions so that it can maintain the freedom to practice so essential to its success and to its professional life.

Questions

A. What will be the effect on the medical profession of an increasing percentage of the gross amount spent for medical care being contributed by the governmental sector?	Percentage of Medical Care
B. What will the effect be on private practice when Public Health becomes more involved in medical care and the differences between public health and private health diminish?	Public Health and Private Care
C. How can the effect of Medicare and Medicaid (on the medical care given the people) be evaluated?	Evaluation of Medicare/ Medicaid
D. What voids in preventive health exist that might encourage governmental programs to proliferate further?	Voids in Preventive Health?

---

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2. Forty cases reported.
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7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"*Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Mantesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Pyridoxine HCL . . . . 5 mg.
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For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
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5 mg.
10 mg.
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For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
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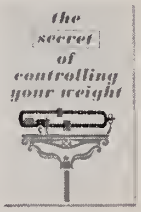
The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444

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Please see Brief Summary on next page.

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Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
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DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Install Pollard to Lead College of Physicians

The 49th Annual Session of the American College of Physicians saw H. Marvin Pollard, M.D., Ann Arbor, installed as national president at the close of the scientific sessions at the War Memorial Auditorium in Boston.

Doctor Pollard, professor of internal medicine at the University of Michigan, heads the gastroenterology section at the U-M Medical Center. He was graduated from the U-M Medical School in 1931 and has been a member of the U-M faculty throughout his career.

He was active in the establishment of postgraduate education programs by the American College of Physicians in South America in 1963. In addition to his activities in the ACP, he serves as treasurer of the Organization of Gastroenterology and as director-at-large of the American Cancer Society. □

ELECT CLAPPER TO SERVE ON BOARD FOR ACP

Muir Clapper, M.D., Detroit, Professor of Medicine at Wayne State University School of Medicine, has been elected to a three-year term on the Board of Governors of the American College of Physicians. Elections were held at the College's 49th Annual Session, recently in Boston. □

WJBK-TV FILMS QUIZ

Herbert A. Raskin, M.D., of Detroit, one of the speakers at the recent MSMS Health Planning Conference, is shown here being interveiwed by Sylvia Wayne, of WJBK-TV, Channel 2 in Detroit, during the Conference. Doctor Raskin discussed Michigan state laws as they relate to problems of alcoholism and drug addiction.

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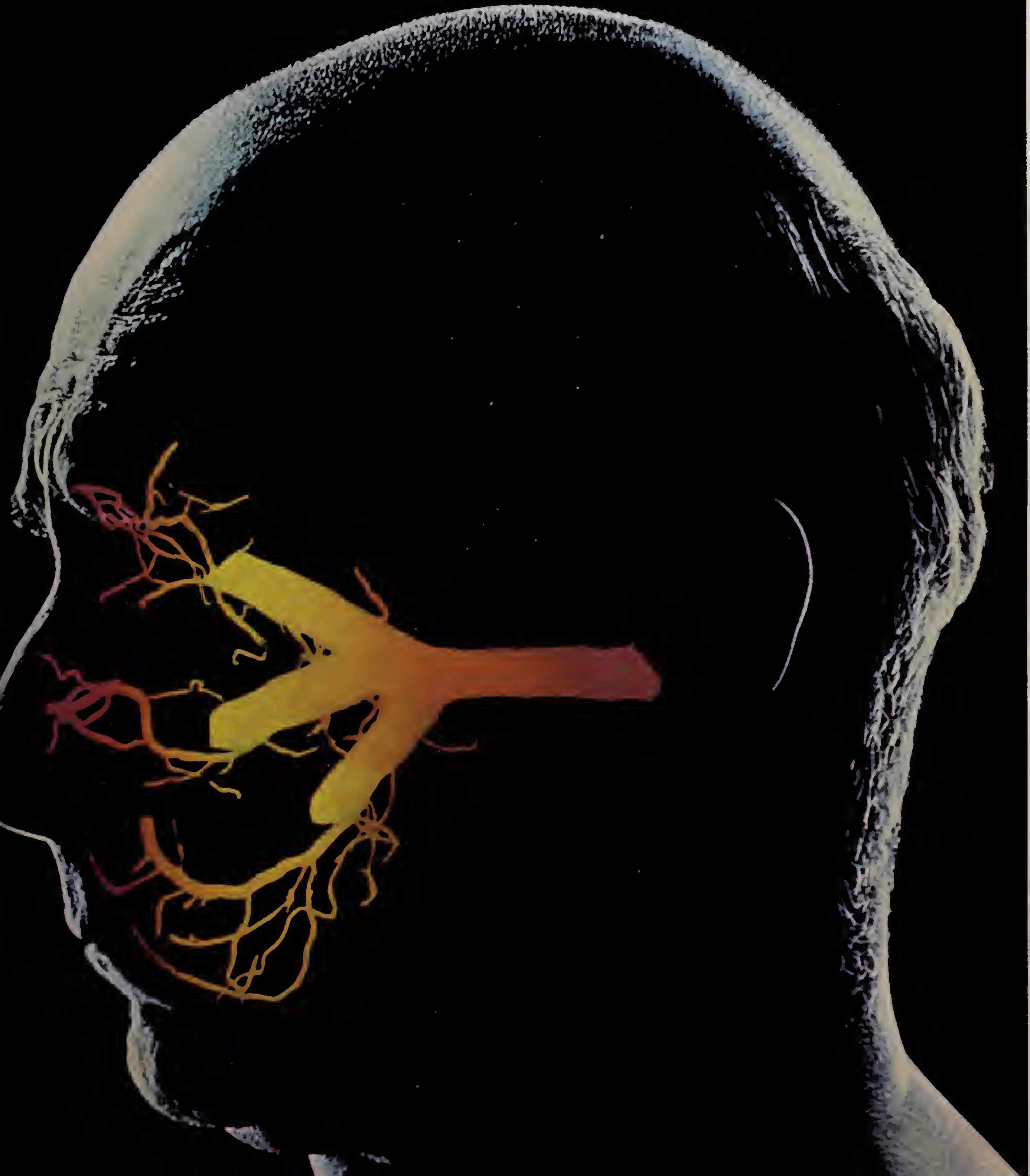
uncommon pain



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Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopi skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancr titis when epigastric pain or unexplained G.I. symptoms develop afte prolonged administration. Other rec tions reported with this class of com pounds include: jaundice, xanthopsi paresthesia, and photosensitization

Average Dosage: 50 or 100 mg. wit breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000

(B)R2-46-230-D

For full details, please see the complete prescribing information.

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New

Tegretol®

carbamazepine

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

arning

atal cases of aplastic anemia have been reported following treatment ith Tegretol. Agranulocytosis, thrombocytopenia and transitory ukopenia have also been observed.

omplete blood and platelet counts should be done prior to and at regular tervals during treatment with the drug (see recommendations under mportant Note and Precautions") to help in the early detection of serious ne marrow injury. Abnormalities in initial blood tests should rule out e of the drug. Also, patients should be made aware of such early toxic gns of a potential hematologic problem as fever, sore throat, mouth cers, easy bruising and petechial or purpuric hemorrhage. Should such gns appear, the patient should be advised to discontinue the drug and to port to the physician immediately.

dication Tegretol is indicated in the treatment of the pain associated ith true trigeminal neuralgia. It is not a simple analgesic and should ever be administered for relief of trivial facial aches or pains.

ontraindication Do not use in those with a known sensitivity to any icyclic compound or in those being treated with M.A.O.I. agents. As long period as possible should elapse before using Tegretol in patients who ave been treated with M.A.O.I.'s, with a minimum of 7 days. In such ases, initial dosage should be low and the patient's reaction to gradual crements closely observed.

portant Note and Precautions Familiarity with the clinical symptoms hich lead to an accurate diagnosis of true trigeminal neuralgia and with e complete prescribing information, careful patient selection, a orough examination before treatment and close patient supervision roughout the treatment period are essential to the safe and effective e of this drug.

here feasible, Tegretol should not be used in conjunction with any potent ug which may increase the possibility of toxic reactions.

pregnancy, the drug should not be prescribed during the first trimester d thereafter only to patients in whom the clinical situation warrants the tential risk. It should not be administered to nursing mothers.

atients with increased intraocular pressure should be closely observed ring treatment with this drug because of its anticholinergic effect.

ecause of the drug's relationship to other tricyclic compounds, the possility of activation of latent psychosis and, in the elderly, of confusion or itation, should be considered.

zziness and drowsiness may occur and patients should be cautioned out the hazards of operating machinery or automobiles and of engaging other hazardous tasks.

e cautiously in patients with a history of coronary artery disease, ganic heart disease, congestive failure or liver disease.

fore initiating therapy, the following laboratory procedures should performed:

Complete blood and platelet counts which, if abnormal, should rule out e use of the drug.

Baseline evaluations of liver function.

ring treatment with Tegretol, the following laboratory procedures should performed:

Complete blood and platelet counts should be done at intervals of one eek during the first month of drug treatment, every two weeks during the cond and third months, and at monthly intervals thereafter for as long the patient is taking the drug. A trend toward a decreasing white blood ll count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.

2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.

Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.

Dosage and Administration The drug should always be taken with meals, if possible.

Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.

Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.

At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.

Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A

For complete details, please see Prescribing Information.

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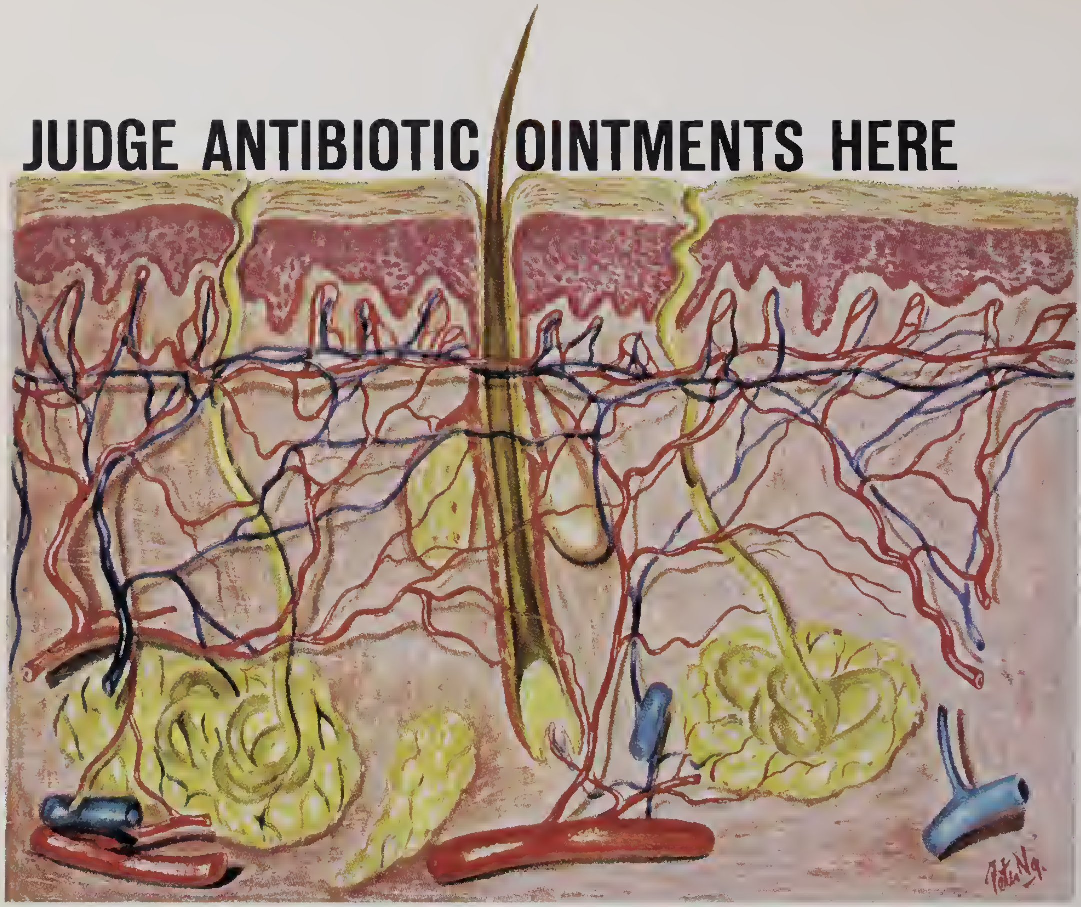

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B —bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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State Reports Year Of PKU Testing

BY MICHIGAN DEPARTMENT OF PUBLIC HEALTH

During the 1967 phenylketonuria testing program, the total number of Guthrie tests performed on newborns in 204 hospitals in Michigan was 157,583. The total number of births in Michigan during 1967 was 161,637. There was a total of 107 presumptive positive tests. Thirteen newborn infants with PKU were identified, bringing the incidence rate for Michigan in 1967 to one in approximately 12,000 live births.

The relatively large number of presumptive positive tests is worthy of mention. Most of them occured in infants of low birth weight, particularly infants receiving high protein feedings. A number of infants who initially presented low grade but persistent elevations of blood phenylalanine, on the other hand, eventually had the diagnosis of atypical or "mild" PKU confirmed. For this reason, all infants with presumptive positive tests received very careful follow-up.

PKU DIET BOOKLET REVISED

A revised edition of the booklet "The Low Phenylalanine Diet" is now available. This revision replaces the two previous publications "The Low Phenylalanine Diet — for Professional Use" and "A Diet Guide for Parents of Children with PKU." It is printed with a washable plastic cover and is spiral bound so that it may be used by the mother while actually preparing food in the kitchen. It has been developed by the Nutrition Section, Michigan Department of Public Health, with the cooperation of other institutions, agencies, and commercial companies.

The booklet has been prepared as a working guide for the parent, and includes information of the disease, and the steps involved in planning the diet according to the physicians prescription. More emphasis is placed in this booklet on the diet of the newly-diagnosed *infant* along with guidance for the parent in making the transition in feeding from infancy to toddler stage.

Copies of this booklet are available free within the State of Michigan and may be requested from the Nutrition Section, Michigan Department of Public Health, Lansing, Michigan 48914. □

David W. Knox, M.D., left, intern at Midland Hospital, received a $1,000 Mead Johnson award for Graduate Training in General Practice during the Annual MSMS Spring Clinic in Midland. Presentation was made by Lee Feldkamp, M.D., right, Plymouth, president of the Michigan Academy of General Practice. Doctor Knox received his M.D. degree from Ohio State University College of Medicine in 1967 and is now completing his first year of family practice training in Midland Hospital's program. The scholarship award is one of 12 granted annually by the American Academy of General Practice under a grant from Mead Johnson Laboratories. Charles A. Sanislow, M.D., seated center, Midland, was chairman of the day. A. Carl Stander, M.D., MSMS councilor, and Robert E. Bowsher, M.D., Director of Medical Education at Midland Hospital, assisted with the arrangements for the MSMS postgraduate educational program.

To fight TB-find it first!

Make tuberculin testing routine with every physical examination.

TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330–8/6135

ACTIVITIES, PROJECTS

DOCTORS, WIVES FURNISH KIMBALL MUSEUM ROOM

The Woman's Auxiliary to the Calhoun County Medical Society is furnishing the Medical Room of the historic Kimball House Museum in Battle Creek.

Originally belonging to the late Arthur Kimball, M.D., the house was given to the Junior League of Battle Creek for development as a museum.

The Calhoun County Medical Society has donated $900.00 to the Woman's Auxiliary to paint and furnish the Medical Room.

Francis L. Lam, M.D., president of the Calhoun County Medical Society, reports that the equipment in the room dates back to about 1870. It includes an examining table, surgical instruments, an antique rocker, and a microscope.

"One of the interesting items," Doctor Lam said, "is an old doctor's ledger. It contains reference to physician's fees being paid with a cord of wood or two chickens." ☐

US SURVEY POINTS TO DANGERS OF SMOKING

The new U.S. Public Health Survey of smoking-health has reported the following findings about the harmful effects of smoking:

Members of the nation's labor force who smoke cigarettes spend some 33 per cent more time away from work because of illness than do persons who have never smoked.

Women who smoke cigarettes, including both housewives and those who work outside the home, spend 17 per cent more days ill in bed than women who have never smoked.

In addition, people who smoke have more days in which they have to cut down on their usual activities because of illness.

The relationship between smoking and illness is particularly strong for such diseases as chronic bronchitis, cardiovascular disease, and peptic ulcers. What has long been known about the relationship between smoking and death from these diseases is now shown to be true of illness and disability as well. ☐

Jaycees Sponsor Many Local Health Projects

Through their continuing concern for Community Development, Michigan Jaycees have been active in various health issues around the state. VD education, measles innoculation, and fluoridation — these are just a few of the areas in which this dynamic group has been involved.

The Livonia Jaycees launched a measles innoculation program. The Wayne County Medical Society helped by providing a doctor, two nurses, and two technicians. American Red Cross provided clerical help and Bank of Detroit supplied a teller to handle donations.

The Fremont Jaycees, with the help of the Newaygo County Medical Society and the county dental association and other groups, got the public support necessary for the City Commission to approve fluoridation of city water.

The Fowler Jaycees piloted a VD education project in Clinton County by presenting 28 programs to various community organizations thereby awakening the public to the need for VD education among young people and teen-agers.

Mount Clemens Jaycees are taking leadership in Project Showboat. Aim of this program is to raise $112,000 to buy a houseboat and convert it to a small floating clinic for use on the Mekong River in Southeast Asia by the Thomas A. Dooley Foundation. The clinic will help local people establish their own basic care centers. ☐

OAKWOOD DIRECTOR CITED

Neil McGinniss, director of Oakwood Hospital, Dearborn, recently received the Key Award, highest honor conferred by the Tri-State Hospital Assembly, during the annual meeting in Chicago. Mr. McGinniss, a past president of the Michigan Hospital Association, is in his eleventh year as director of Oakwood Hospital. ☐

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How About Anti-Smoking Poster for Office Display?

An excellent poster which reads "1,000 Doctors Have Quit Smoking Cigarettes (maybe they know something you don't)" has been issued recently by the National Clearinghouse on Smoking and Health.

Any physician who would like to receive one, or a supply of them, can get them from MSMS headquarters, P.O. Box 152, East Lansing. ☐

WSU MAN SELECTED AS MARKLE SCHOLAR

Robert F. Wilson, M.D., assistant professor of surgery at Wayne State University School of Medicine, has been named a Markle Scholar by the Markle Foundation in New York. To promote his professional development, Doctor Wilson will receive a $30,000 grant over a five-year period.

Doctor Wilson received his medical degree from Temple University, and has served on the Wayne faculty since 1963. His research has been in the basic mechanisms of shock and other metabolic derangements in humans. ☐

One of the sidelights to the 1968 WSU Medical School Alumni Clinic Day in Detroit recently was a special art exhibit composed of work by alumni physicians and their wives. Discussing one of his works with Mary Sylvester, a reporter from the Royal Oak Daily Tribune, is Joseph R. Montante, M.D., of Orchard Lake. Thirty physicians and their spouses contributed 70 pieces of art. The show was coordinated and hung by David Jacknow, M.D., of Huntington Woods.

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PUBLIC RELATIONS

Counties Invited to Join Community Health Week

BY BROCK E. BRUSH, M.D., CHAIRMAN
MSMS COMMITTEE ON PUBLIC RELATIONS

Every component medical society in Michigan is encouraged to join the MSMS observance of the 1968 Community Health Week, October 20-26.

Three timely themes — drug abuse, physical fitness and health careers — have been selected by the AMA for this sixth annual observance of Community Health Week across the nation. Community Health Week is a public service program inaugurated by the AMA's House of Delegates in 1962.

Goals of the observance are for state and county medical societies, in cooperation with other members of the community health team, to present meaningful programs aimed at furthering public awareness of the wide variety of health services and facilities existing at the community level, to call attention to present health problems and potential solutions, and to call attention to continuing medical advances.

Your MSMS Committee on Public Relations will propose possible county-level projects, and offer advice and guidance. ☐

Urges Better Evaluation Of Health Messages

BY PETER HOHEISEL
OF THE MSMS STAFF

"What is often called evaluation of health education is only a description of activity rather than outcomes," said a University of Michigan psychologist at a panel on "Psychological Influences on Health Behavior" during the AMA's recent 3rd National Conference on Health Education of the Public in Chicago.

Speaking on "Health Education Research Relating to Health Behavior," James W. Swinehart, Ph.D., a research associate and lecturer in the U-M School of Public Health, noted three basic needs in health education today: (1) To reduce the discrepancy between belief and behavior, (2) To obtain and use more information on audience characteristics when planning health education programs, and (3) To do more and better evaluation of health education efforts.

Doctor Swinehart described the process through which a health education message is transmuted from information to action as six basic steps: Distribution, Exposure, Attention, Learning, Acceptance, and Action.

"If there is a gap between any of the six steps," Doctor Swinehart explains, "the desired action may not take place. A person could go through the first five without taking the last and most important step to action."

"There has been an assumption on the part of health educators and physicians that if you give people information they will act rationally on it," he continued.

"Several studies have shown that this is not the case," the University of Michigan Psychologist said.

Doctor Swinehart cited a study of policemen in California as to whether or not they use seat belts when driving their own automobiles. The assumption would be that as a segment of the population they would have a higher consciousness of the importance of the seat belt since they see the results of accidents when people are not wearing them and since they are required to wear them in their own patrol cars. The study, however, did not show any higher incidence of the use of seat belts among policemen.

To close the gap between information and action, Doctor Swinehart recommends more detailed research into the specific characteristics of the audience which is to be reached with a health message.

He recommends that health educators find out "What kind of worries do people have about specific diseases. Is it the pain? The cost of treatment? The attitudes of other people toward the disease?"

"Once these and other matters are determined with some precision," Doctor Swinehart said, "A message can be tailored to a specific audience segment, and, in my opinion, be much more effective. If we can get a better idea of who the audience is, we can know more definitely that the 6 steps will take place." ☐

DID YOU KNOW THAT

"Would-be doctors entering medical school this fall may be astonished to learn that 80 per cent of the medical practice they will be taught was discovered since most of them were born."

— American Education
Journal of HEW
March 1968

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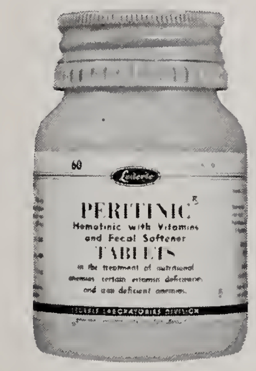
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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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BROWN SPIDER MOVING NORTH; SYMPTOMS ARE EXPLAINED

(Note: The following are excerpts from a National Clearinghouse for Poison Control Centers Bulletin distributed in Michigan by the Division of Epidemiology, Michigan Department of Public Health.)

Although the brown spider has been recognized to exist in most parts of Oklahoma, Kansas, Arkansas, Texas, Louisiana, Mississippi, Alabama and Tennessee, reported activities would indicate a northward migration of the species.

A three-year-old boy living in Pocahontas, Illinois died two days after having been bitten by a spider in bed; a *Loxosceles reclusa* was found in the home.

The brown spider varies from $3/10$ to $1/2$ inch in body length and is yellowish to dark brown in color. This spider is distinguished by the presence of three pairs of eyes arranged in a semi-circle on the fore part of the head and a violin-shaped dark marking on the cephalothorax immediately behind the semi-circle of the eyes.

The spider is usually found in dark spaces and its irregular webs are spun near cracks in foundations and in or around steps, containers, or hanging clothes. The spider is not considered to be aggressive and most bites have occurred when spiders were trapped beneath clothing or bedding.

The systemic symptoms are fever, restlessness, albuminuria and generalized pruritic rash (scarlitiniform) over the entire body. The toxin has been shown both experimentally and clinically to produce acute hemolytic anemia with hemoglobinuria and hematuria. Jaundice occurs in about 33% of the patients. The systemic effects may last up to five days and may result in the patient's death. The local reaction is of inflammation discoloration, echymosis, necrosis, and tissue sloughing which may persist for several weeks. A local reaction is the most common and, except for its prolongation, is usually relatively benign. The treatment is symptomatic and supportivve, but steroids and antihistomines may be of value.

Useful references on the subject of the *Loxosceles reclusa* are: James et al, Am. J. Dis. of Child., Sept. 1961, pp. 145-148; JAMA, 185-11, Sept. 1963, Arachnidism in the United States, pp. 839-843; Schreiner, G. F. and Maher, J. F., Toxic Nephropathy, Am. J. of Med., 38:438, March 1965; Nation Pest Control Association — Technical release No. 11-64, June 24, 1964, No. 11-58, June 17, 1958.

SOCIO-ECON

Florida, Michigan Lead Nation in Growth In Personal Income

Herbert C. Dejonge, Director, Department of Commerce of the State of Michigan, made the following observations about Michigan's economic health in his article "Michigan Expanding Economy" which appeared in a recent issue of *Michigan Challenge.*

So far in the decade of the 60's Michigan ranks second among the largest states in percentage growth for total personal income.

Since 1962, Gross State Product — the total output of goods and services — jumped 50.6% while gross national product is up 40.2%. Nonfarm employment in the State climbed from 2,672,000 to 3,168,000 or 18.6%; the U.S. average gain was 13.9%.

Since 1963, retail sales in Michigan have jumped 33.6%, versus a rise of 27.1% for all states.

THE 10 LEADING STATES IN TERMS OF INCREASE IN PERSONAL INCOME
(in millions of dollars)

	1960	1966	Change	% Increase
Florida	9,746	15,410	5,664	58.1
Michigan	18,203	27,685	9,482	52.0
California	42,980	65,002	22,022	51.2
Indiana	10,225	15,230	5,005	48.9
Texas	18,535	27,319	8,784	47.4
New Jersey	16,528	23,767	7,239	43.8
Illinois	26,718	38,089	11,371	42.6
Ohio	22,729	31,670	8,941	39.3
New York	46,281	63,669	17,388	37.6
Pennsylvania	25,395	34,434	9,039	35.6

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* 1904 - 1967

Say you saw it in Michigan Medicine

Auxiliaries Collect Drugs, Supplies for Overseas

BY MRS. W. G. GAMBLE, JR., PRESIDENT
WOMAN'S AUXILIARY TO MSMS

International Health Activities is a most important Auxiliary program, for it is dedicated to helping the less fortunate persons of our own and other nations. Through our national, state, and local International Health Activities committees, we are attempting to ease the critical shortage of medical supplies throughout the world.

Our method is simple — the Auxiliary at the county level collects unused supplies and sends them to a proper distribution agency (one that is certified by the U.S. Food and Drug Administration) for shipment to foreign countries. In Michigan the supplies go to World Medical Relief, a certified agency whose headquarters are in Detroit.

WHAT DO WE COLLECT?

Pharmaceutical samples are a major item for collection. However, they must be in perfect condition and up-to-date. A registered pharmacist at World Medical Relief checks all medications before they are distributed to foreign recipients.

Another commodity we collect is medical textbooks which must be at least four years current. Medical and surgical supplies, treadle sewing machines, prostheses of every description, medical journals, used radio equipment for physicians in remote areas, eye glasses (both lenses and frames, and not necessarily together) are all valuable materials which are needed in underprivileged areas here and abroad.

But not only do we collect items such as the ones listed above — we also make useful articles. For instance, if you attended a meeting of the Auxiliary in your county, you would see many members knitting seemingly endless, three-inch or one-inch-wide bands. These knitted bands, after being carefully washed, dried, and wrapped in plastic, become leper bandages. Other bandages are made from old sheeting or pillow cases.

Johnny Coats are another Auxiliary-produced article. They are made from old shirts and are used for hospital gowns by needy persons all over the world.

HOW LARGE AN EFFORT is this project for international health? Some statistics answer the question: In 1966-67 the Auxiliary to the MSMS sent 15,337 pounds of drugs and many large pieces of equipment to World Medical Relief. In addition, approximately 1000 pounds of materials were sent to World Vision. This year's poundage is even more impressive. Over 30,000 pounds of medical supplies have been collected thus far, this year, for the International Health Activities program. Of course this does not include approximately $500 that has been donated to the cause of international health.

This year's state chairman for IHA is Mrs. R. F. Hauer of Fowlerville. Mrs. Hauer joins me in requesting that you physicians continue helping us, by contributing surplus supplies, to help others.

In this way we can all show our concern for our less fortunate neighbors. ☐

APHA Convention In Detroit to Focus On Urban Questions

The urban health crisis and health planning are two of the major items the 96th annual meeting of the American Public Health Association will study at its November 11-15 meeting at Cobo Hall in Detroit.

Current APHA president and chairman of the local committee for the annual meeting is John J. Hanlon, M.D., Detroit and Wayne County Director of Public Health. ☐

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MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING MAY 31, 1968

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	45	149	202	790
Whooping Cough	25	95	211	480
Diphtheria	0	0	0	0
Mumps	2432	2379	11808	10512
Scarlet Fever & Strep Sore Throat	1001	1225	6105	8296
Tetanus	1	1	2	1
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	272	185	883	931
Salmonellosis (Other than S. Typhi)	67	45	272	227
Typhoid Fever (S. Typhi)	0	0	0	4
Shingellosis	22	78	93	233
Aseptic Meningitis	4	3	24	9
Encephalitis	16	14	47	47
Meningococcic Meningitis	11	8	48	33
Influenzal Meningitis	6	8	25	21
Tuberculosis	225	271	1217	1306
Syphillis	546	546	2458	2593
Gonorrhea	1518	1627	7065	6909

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Breathalyzer Effective In Michigan

BY ELMER WHITE, EXECUTIVE DIRECTOR, MICHIGAN PRESS ASSOCIATION

The old slogan, "If you drink, don't drive," may soon be obsolete as Breathalyzers become more common in Michigan. The new slogan seems to be, "If you drink and drive, be prepared to walk."

Arrests for drunk driving increased 78 percent the first four months of 1968 over 1967, Michigan State Police report. Law enforcement agencies throughout the state, from January through April, asked 5,154 drivers to take the test. Seventy-six percent of those tested exceeded the presumptive level of intoxication, and 12% were in the "impaired driving" bracket. Police said 1,214 drivers refused to take the test.

Under Michigan's "Implied Consent Law," refusal is cause for suspension of an operator's license. Secretary of State James M. Hare reports that 1,236 drivers cited for refusing to take the chemical test, 631 persons appealed the license suspension. Licenses were restored, after hearings, in 95 cases and denied in 524; 12 cases were awaiting hearing dates.

There are now 850 Breathalyzer operators in the state, and another 100 will be trained before the current school is completed, State Police say. Instruments have been placed in 40 sheriff offices, 39 city police departments, three township police departments and 59 State Police posts. Forty-seven more will be installed in the near future.

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IN MEMORIAM

R. M. Cooley, M.D., Jackson

Randall M. Cooley, M.D., Jackson radiologist, died May 20. He was 81. Doctor Cooley was a Life Member of MSMS and a Past President of the Jackson County Medical Society. He was affiliated with Mercy Hospital, Jackson.

His premedical studies were done at Kalamazoo College and he was graduated from the University of Michigan Medical School in 1910. He served at the 125th Field Hospital during World War I.

He was president of the Detroit Roentgen Ray and Radium Society in 1956 and was a member of the Radiological Society of North America and the American College of Radiology.

H. F. Dibble, M.D., Detroit

Harry F. Dibble, M.D., Detroit, a delegate to the MSMS House of Delegates from Wayne County for many years, died May 10. He was 79.

Doctor Dibble was a member of the House of Delegates between 1920 and 1950 and served several years on the MSMS News Committee at the Annual Sessions when held in Detroit. He held a teaching appointment in general surgery at Wayne State University from 1921 to 1950.

He was graduated from the Detroit College of Medicine in 1911 and served his internship and residency at Harper Hospital. He was affiliated with Harper and Receiving hospitals until his retirement.

During World War I, he served briefly with the Royal Army Medical Corps and as a Captain in the Medical Corps of the U. S. Army, Base Hospital, France.

Doctor Dibble was a Fellow of the American College of Surgeons, a Life Member of MSMS, and a member of the Academy of Surgery and the Detroit Surgical Society. His medical fraternity was Nu Sigma Nu.

N. H. Goldberg, M.D., Detroit

Nathan H. Goldberg, M.D., Detroit physician, died May 4 at the age of 76.

Doctor Goldberg was graduated from the Vanderbilt University School of Medicine in 1916.

He had practiced in Detroit for the past 35 years, specializing particularly in urology, syphilology, dermatology and surgery. He was affiliated with Wayne County General Hospital.

He was a Life Member of MSMS and a member of Pi Mu medical fraternity.

Joseph Hickey, M.D., Dearborn

Joseph Hickey, M.D., Dearborn general practitioner, died April 12 at the age of 71.

Several times a delegate from Wayne County to the MSMS House of Delegates, Doctor Hickey was a Life Member of MSMS.

He received the M.D. degree from Wayne State University in 1929 and did his residency and internship at Receiving Hospital, Detroit. He served as chief of staff at Oakwood Hospital, Dearborn, from 1954-56 and was also affiliated with Delray General Hospital, Mt. Carmel Mercy and Wyandotte hospitals.

Doctor Hickey was an Associate Fellow of the International College of Surgeons and a member of the American Academy of General Practice and Phi Beta Pi medical fraternity.

G. W. Stewart, Jr., M.D., Saginaw

George W. Stewart, Jr., M.D., Saginaw general practitioner, died May 13 at the age of 58.

Doctor Stewart began practice in Saginaw in 1941 after two years in Owosso. At various times he served as president, vice-president and secretary of the Senior Staff at St. Lukes Hospital in Saginaw. He was also affiliated with St. Mary's Hospital and Saginaw General Hospital.

He received the B.A. degree from the University of Detroit and was graduated from the University of Michigan Medical School in 1937. For four years during World War II he served in the Army Medical Corps and was awarded two Battle Stars for action in the Pacific Theatre.

Doctor Stewart was president of the Saginaw Academy of General Practice in 1953.

SERVICE TO HANDICAPPED, TRIBUTE TO ALMA DOCTOR

A sheltered workshop program for the Central Michigan area soon to be inaugurated in Alma will be a living memorial to the late C. L. Hoogerland, M.D., an Alma physician and pediatrician who died a few years ago. To be known as the C. L. Hoogerland Memorial Workshop, the project will assist the physically, emotionally, and mentally handicapped by providing training and an opportunity to work under sheltered conditions. It will also help to find employment for those who may be able to leave the workshop to accept full-time employment in the community.

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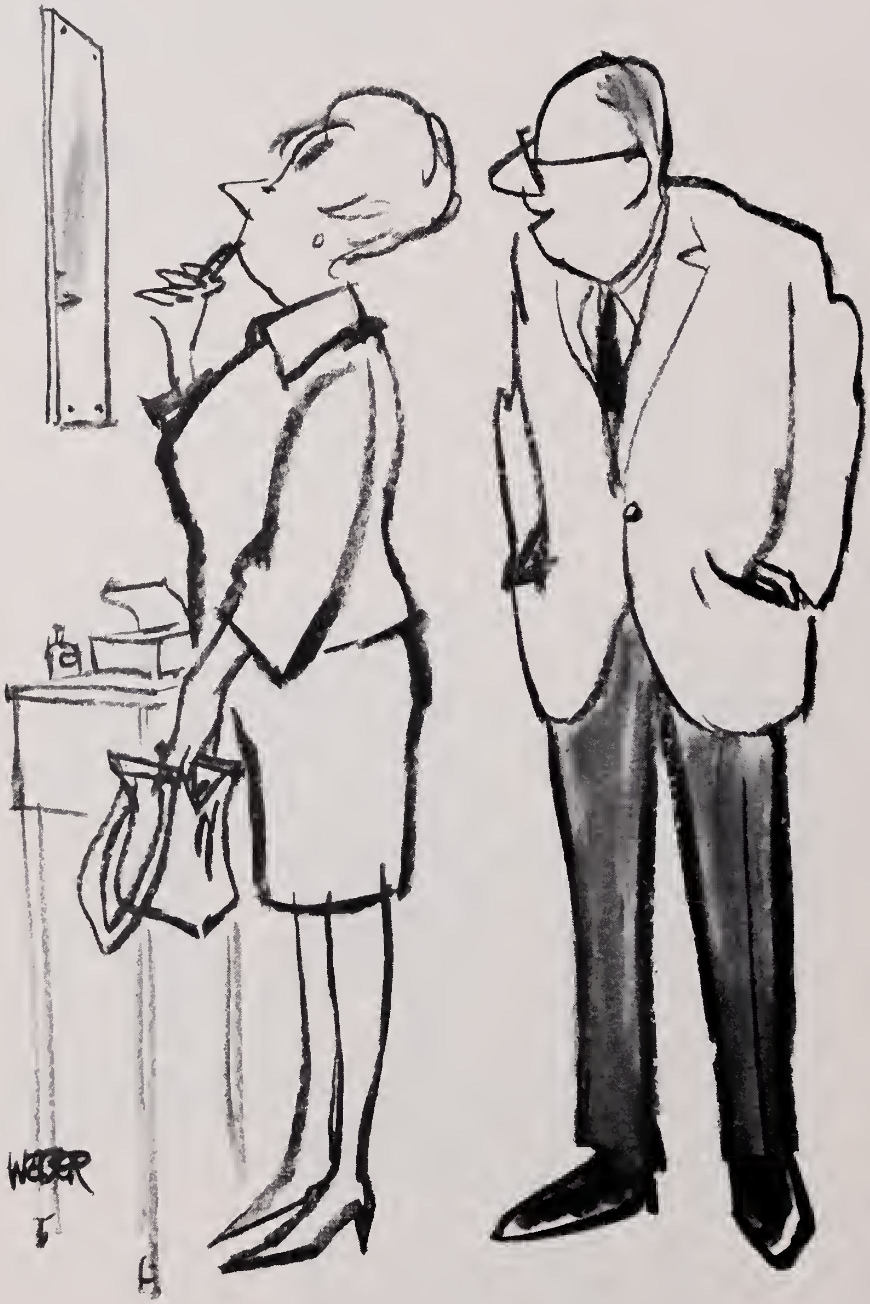

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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FERRIS STATE COLLEGE needs two additional full time staff Doctors for Student Health Center. Thirty-one bed Infirmary and enlarged out-patient facility ready this fall. Excellent opportunity for qualified persons in small quiet college town. Regular hours with rotating night and weekend call. Salary to $18,000 and excellent fringe benefits. Please contact Roy A. Davis, M.D., Area (616) 796-8463 or write in care of Ferris State College, Health Center, Big Rapids, Michigan 49307.

RESIDENTS IN PATHOLOGY: Fully approved 4 year Residency in Pathology available. Modern 460 bed hospital. Well equipped laboratories (6,000 sq. feet), including 12 channel auto analyzer, under the direction of three full time Board Certified Pathologists and PhD Clinical Chemist. Over 250,000 clinical procedures, 200 autopsies and 7,500 surgicals per year. Starting salary $650.00 per month. Apply: Edward W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, Michigan 48912 —Attn: Director of Medical Education. Dr. Richard Pomeroy.

YOUNG GENERAL PRACTITIONER seeks associate in general practice. Partnership possible. Very busy practice includes minor surgery and obstetrics. Modern 150 bed hospital and good consultants in town. College community of 15,000 with 10,000 students in Central Michigan. All churches, good schools. Prefer man under 45 with military obligations fulfilled. Contact: Martin M. Nosan, M.D., 1101 S. Mission, Mt. Pleasant, Michigan 48858.

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WANTED: Pediatrician, certified or eligible, to associate with two certified pediatricians in upper midwest college city of 50,000. Apply to Box number 13, 120 West Saginaw Street, East Lansing, Michigan 48823.

MEDICAL DIRECTOR: Single County Health Department. Population approximately 165,000. Department employs approximately 15. General Health programs. Excellent relationship with physicians' groups. Outstanding year round recreational activities. Excellent schools. Desire M.D., M.P.H.; will consider M.D. willing to obtain M.P.H. with assistance, within three years of employment. Location Western Michigan. Salary open, in excess of $21,000, depending on qualifications and Experience. Many fringe benefits. Send resume to James V. Wells, Muskegon County Board of Health, County Building, Muskegon, Michigan 49440.

FIRST YEAR RESIDENT OBSTETRICS & GYNECOLOGY: University of Michigan teaching hospital, Ann Arbor, with second and third year residents, needs first year resident 9-1-68. Private and clinic service. Allied residencies in Surgery, Medicine and Pathology, with full quota of 20 rotating interns plus University of Michigan Medical students. Non-pharmidal, $675/month ($8100 annually). Reply C. W. Newton, M.D., St. Joseph Mercy Hospital, Ann Arbor, Michigan 48104.

MEDICAL TECHNOLOGISTS: ASCP or eligible. Edward W. Sparrow Hospital, modern and air-conditioned, 460 bed general hospital. Extensive laboratory expansion in progress. Start $575.00 per month with increases to $624.00. Apply Personnel Office, Edward W. Sparrow Hospital, Lansing, Michigan 48912.

WANTED: INTERNIST for small group in Fox River Valley. Recreational center with emphasis on fishing and boating. Newly remodeled 400 bed hospital. Salary with partnership opportunity after first year. Begin 1969. Contact Dr. V. G. Guenther, 417 Mt. Vernon St., Oshkosh, Wisconsin 54901.

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WANTED: ORTHOPEDIC SURGEON, board certified or eligible to join two-man partnership. Very active widely varied practice. Two fully equipped hospitals. Town of 40,000 on Lake Huron, fifty minutes from downtown Detroit. Excellent living, sailing, recreational area. Starting salary up to $30,000. Association thereafter. Write C. O. Townley, M.D., or S. C. Walker, M.D., 1209 Tenth Street, Port Huron, Michigan 48060 or call collect (313) 982-9923.

G. P. NEEDED for active General Practice in Flint. To associate with young active G.P. Salary open. Partnership if desired. Call or write Harry S. Newman, M.D., 302 E. Court St., Flint, Mi 48503 (313) 235-5552.

BOARD ELIGIBLE OR CERTIFIED INTERNIST DESIRED. Opportunity for consultation-type practice. Rapidly expanding medical community in central Michigan, area of 40,000 population. If interested call collect (517) 463-1866 or write: Wilmer M. Rutt, M.D., 245 Warwick Drive, Alma, Michigan 48801.

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MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

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Ralph Blocksma, M.D., Grand Rapids, visited the Dominican Republic and was received by president Dr. Joaquin Balaguer. He was honored for the efforts made by the Medical Assistance Program of which Doctor Blocksma is chairman, to reduce infant mortality in the Dominican Republic.

Bonnie R. Wolfram, M.D., Detroit, participated in the National Budget and Consultation Committee Meetings in New York, held annually to review budget requests from national agencies in federation, supported by United Funds.

Chester S. Koop, M.D., Flint, is the new president of the Genesee County Tuberculosis and Respiratory Disease Association.

James C. Cook, M.D., Detroit, clinical associate professor at WSU, has been named a delegate of the American Roentgen Ray Society to the International Congress of Radiology in Tokyo in October, 1969.

Edward D. Sage, M.D., Kalamazoo, recently celebrated his 90th birthday and announced his plans to retire after 66 years of active practice in the community. He received a citation from the Latvian Lutheran church.

Three Michigan doctors presented papers at the meeting of the American College of Surgeons held in Munich in cooperation with the German Surgical Society. They are Robert W. Bailey, M.D., Ann Arbor, Reed O. Dingman, M.D., Ann Arbor, and James M. Pierce, Jr., M.D., Detroit.

Harold L. Upjohn, M.D., Kalamazoo, has been named Vice President of the Upjohn Company in charge of Medical Affairs. He had been Director of Medical Research for the company since 1962.

Frederick Van Duyne, M.D., Flint, was elected a delegate to the Republican National Convention from Michigan's 7th District. Also chosen at the Republican State Convention were Donato Sarapo, M.D., Adrian, alternate delegate from the 2nd District and Jack M. Stack, M.D., Alma, alternate delegate from the 10th District.

Harry A. Towsley, M.D., Ann Arbor, has been appointed to the Board of Trustees of Northwood Institute in Midland.

Raymond W. Waggoner, M.D., Ann Arbor, has been honored by two medical groups. The American College of Psychiatrists presented the E. B. Bowis Award for 1968 to him at the annual meeting of the College in Boston in recognition of his "outstanding achievements, contributions, and leadership in the field of psychiatry." A special Resolution of Appreciation by the Michigan Society for Mental Health expressed esteem and lauded him for his many years of service to the mentally ill in Michigan.

James J. McClendon, M.D., Detroit, has been appointed president of the Detroit Board of Health.

Willard Hayes, M.D., Norway, was honored at a public dinner at which he received the 1968 "Citizen of the Year" award given by the Iron Mountain Lions Club for outstanding humanitarian and civic endeavors.

J. Daniel Cline, M.D., Midland, was chosen "Citizen of the Year, 1968" by the Midland Civitan's Club for his "unselfish civic service and the promotion of good citizenship by example, and specifically for his work with young people and the promotion of interest and excellency in athletics."

Morley B. Beckett, M.D., Ann Arbor, has been named Doctor Director Emeritus of the University Health Service and Professor Emeritus of Community Health Service by the Regents of Alumni of the University of Michigan. He was director of the university health service and professor of public health from 1955 until his retirement this year.

E. F. Arscott, M.D., Rogers City, will soon be leaving his private practice to become assistant medical director of the Ford Motor Company, Cleveland.

Open-eyed nights

oo tense to sleep...too ired to get up. Early to ed, late to rise, and not nuch sleep at that, the patient with severe psychic ension is understandably tired. His tensions and verreactions to the day's stresses may interfere vith proper sleep, and his inability to face the day's ctivities can produce an ever-worsening pattern. y relieving psychic tension, Valium® (diazepam) acilitates sleep, particularly with an h.s. dose. In nany patients, the usefulness of Valium has been lemonstrated in relieving psychic tension alone or vith secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

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ndications: Tension and anxiety states; somatic complaints hich are concomitants of emotional factors; psychoneurotic ates manifested by tension, anxiety, apprehension, fatigue, epressive symptoms or agitation; acute agitation, tremor, elirium tremens and hallucinosis due to acute alcohol withrawal; adjunctively in: skeletal muscle spasm due to reflex asm to local pathology, spasticity caused by upper motor euron disorders; athetosis, stiff-man syndrome, convulsive isorders (not for sole therapy).

ontraindications: Known hypersensitivity to drug; children nder 6 months of age; acute narrow angle glaucoma; may be sed in patients with open angle glaucoma who are receiving ppropriate therapy.

arnings: Not of value in treatment of psychotic patients, d should not be employed in lieu of appropriate treatment. s with most CNS-acting drugs, caution patients against hazdous occupations requiring complete mental alertness (*e.g.*, erating machinery, driving). When used adjunctively in conlsive disorders, possibility of increase in frequency and/or verity of grand mal seizures may require increase in dosage standard anticonvulsant medication; abrupt withdrawal in ch cases may also be associated with temporary increase in equency and/or severity of seizures. Advise patients against multaneous ingestion of alcohol and other CNS depressants. ithdrawal symptoms (similar to those with barbiturates and cohol) have occurred following abrupt discontinuance. Keep ldiction-prone individuals (such as drug addicts or alcohols) under careful surveillance because of their predisposition habituation and dependence. Use of any drug in pregnancy, ctation or in women of childbearing age requires that potenal benefit be weighed against possible hazard.

recautions: If combined with other psychotropics or antinvulsants, carefully consider individual pharmacologic effects particularly with known compounds which may potentiate tion of Valium (diazepam), such as phenothiazines, nartics, barbiturates, MAO inhibitors and other antidepressants. mploy usual precautions in the severely depressed or in those ith latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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